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The Institutional and Archival Social Ecologies of a State Mental Hospital's Records, 1870 to Present

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The Institutional and Archival Social Ecologies of a State Mental Hospital's Records, 1870 to Present

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Dedication

To Drs. Faye and Willie Dong

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The Institutional and Archival Social Ecologies of a State Mental Hospital's Records, 1870 to Present

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The University of Texas at Austin, 2015

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In this dissertation, I construct the social ecologies of records from a state mental institution in order to explicate the impact and value of the records to different groups and individuals over time, with a focus on the social implications of the organizational records becoming archival objects. I engage with the repercussions of the Health Insurance Portability and Accountability Act of 1996 on the access of health information, and posit what are the social complexities underlying potentially sensitive institutional records in general. My research site is a still-active facility that arose out of the Reconstruction South, and exclusively served the state's African American population until it was desegregated after the Civil Rights Act of 1964. Through the theoretical frameworks of social constructionism, and specifically Actor-Network Theory, I examine the discursive work that mental hospital records perform in order to mediate relationships between people. The design of the research is rooted in sociological and archival activist research so that I can focus purposefully on the power inequalities and silent participants within record ecologies. I collected data for my study from archival registers and minutes from several distinct eras in the hospital's history and from interviews with people who currently have or had substantive connections to the creation, management, or use of the

archival collection, including former and current facility personnel. In order to construct themes from the data, I use grounded theory with an emphasis on situational analysis and critical discourse analysis. By employing multiple means of analysis, I form a longitudinal picture of the human and non-human participants involved in record-creation and record-keeping work at the hospital. I also develop several major themes, including accountability, classification, the development of psychiatry, and power, which point to the overarching institutional use of records to help bureaucratic bodies control various populations and maintain hierarchies. In illustrating how the records support and perpetuate hegemonic structures, I advocate for a pluralization of the stakeholders who have the right to be included in the discussions about if and how the historical records are to be preserved and accessed.

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Chapter 1: Introduction

RESEARCH OVERVIEW

"You live and you die by your medical records." A senior level administrator of a state mental facility pragmatically said these words to me while we sat in a quiet corner of a public library one warm autumn afternoon in 2013. We had met at the library so we could talk about the medical records created and maintained at her facility, Larch Point Hospital (LPH).[1] We were also there to discuss the ongoing efforts by a group of academics from the University of Texas, including me, to preserve and make accessible the extant historical records that remain under the hospital's custodianship. In 2010, I became the archivist and preservation specialist for the LPH archives project, which led to my interest in writing a dissertation that examined the social impact of this institution's medical records in their original hospital environment and as they transition into the archival domain. The administrator with whom I spoke at the library was one of several hospital professionals that I interviewed. Her statement is illustrative of the power of medical records, whether still in use by its creators or as historical documents, to define an institution and its network of stakeholders.

The hospital's archival collection spans over one hundred years and reflects major shifts in psychiatry, de jure and de facto race relations, and institutional recordkeeping practices. I began the archival project believing that the preservation of mental health records is important for our cultural heritage record, in addition to being a valuable resource for medical research. As heritage artifacts, these records illustrate changes in mental health care, the work of hospital staff, and the lives of institutionalized patients in the past. There is also potential for emergent archival communities, such as former patients and hospital staff, to use and engage with such records in ways that are not yet

[1] Larch Point Hospital is a pseudonym.

known. While the historical significance and prospective use value of the collection seemed readily apparent to me before I even saw the materials, it was not until after I worked extensively with them and spoke on and off the record with staff and researchers that I better understood the complex relationships between the collection and its stakeholders. Therefore, in addition to discovering the ways in which archival mental health records can be valuable resources, I had to ask: can the records convey information that is potentially too emotionally painful or socially/politically damaging for the living? If so, is it because of the information recorded in the documents or the continued existence of the physical documents themselves? How could health records that are medically inactive but still part of social relationships negatively impact people today?

I use the phrase "mental health records" to encompass multiple document categories that serve different purposes in the hospital environment. First, there is the formal documentation that tracks a patient's progress at an institution from admission to treatment to discharge. These medical records are created at each step, some that follow the patient throughout his stay and are continually updated or altered. The second type of mental health records are the institutional administration documents that record the day-to-day activities of a hospital or the high-level meetings held by hospital boards. Both types of records often fulfill recordkeeping requirements for internal and third-parties oversight. Finally, the third category encompasses the informal documentation that is created by staff members for themselves as reminders. Some of the document types, such as individual patient charts and the Master Index Cards, are standardized forms, while others, such as nurses' and doctors' memoranda, are not; both change over time in terms of media, format within the record, content, and how they are organized and stored to reflect new workplace practices and recordkeeping technologies.

The crux of the dilemma with the preservation of mental health records is if and how these records should be accessible after they are no longer needed by the medical facility. On one hand, mental health records are created in a specific type of work environment and intended to serve a singular purpose, then be disposed of or filed away

for hospital use only. Health professionals primarily create health records in order to facilitate patient care or as documentation toward staff and institutional accountability. These records are at once intensely personal both for the record creator as a reflection of her work and the institution's workplace procedures and for the patients who are represented by the hospital documents. On the other hand, these records have the potential to be a rich source of information on workplace practices, cultural norms, and the lives of the mentally ill and mentally disabled. They reflect a specific time period and environment that might otherwise not be remembered or understood without primary resources. In addition, archival mental health records can serve as valuable longitudinal data for epidemiological research. In the United States, federal and state lawmakers have begun to recognize the multiple roles of mental health records across different communities of practice (e.g., doctors, nurses, patients, records managers, archivists, descendants, researchers).

The United States' Health Insurance Portability and Accountability Act of 1996, or HIPAA, its accompanying federal regulation, the Privacy Rule (2002), and the state laws regarding the retention and disposition of health records continue to evolve to address the potential positive and negative consequences of preserving and making inactive health records accessible to the public. In the 2013 revision of the Privacy Rule, one of the amendments allows patient records to become available to the public 50 years after the individual's death. Information professionals and researchers alike have become increasingly vocal about the need to make health records more accessible for historical research purposes. While the progress that is being made in the legal domain is promising in terms of developing laws and regulations that better reflect the complex relationship between archival records and people, the research domain of mental health records and their effects on and between people over time is one that remains little studied. I believe archivists are key figures in mitigating the tension inherent in restoring previously anonymous or obscure decedent patients with biographic identities while risking the

psychic pain of descendants learning about their ancestors' medical history through records and, by proxy, their own potential genetic risks.

The focus of my dissertation is to examine the social ecologies of mental hospital records and the implicit and explicit roles records play within these worlds. Mental hospital records belong to a genre of institutional records that lends itself well to the examination of difficult ethical and legal questions about agency, access, ownership, and privacy across a number of stakeholders, including patients, hospital staff, researchers, and community groups. Having been inspired by the rich sociological work that employs Actor-Network Theory (ANT), I ground my research in ANT in order to examine the social roles of records as mediating objects. However, I use the word "ecology" here rather than the ANT terminology of "network" because the former more strongly connotes a holistic picture of a milieu that encompasses not only the ever fluctuating actant networks but also accounts for the omnipresent effects of time. Time plays a part in material degradation, legal restrictions, public opinion, and living stakeholders, just to name a few important considerations in this study.

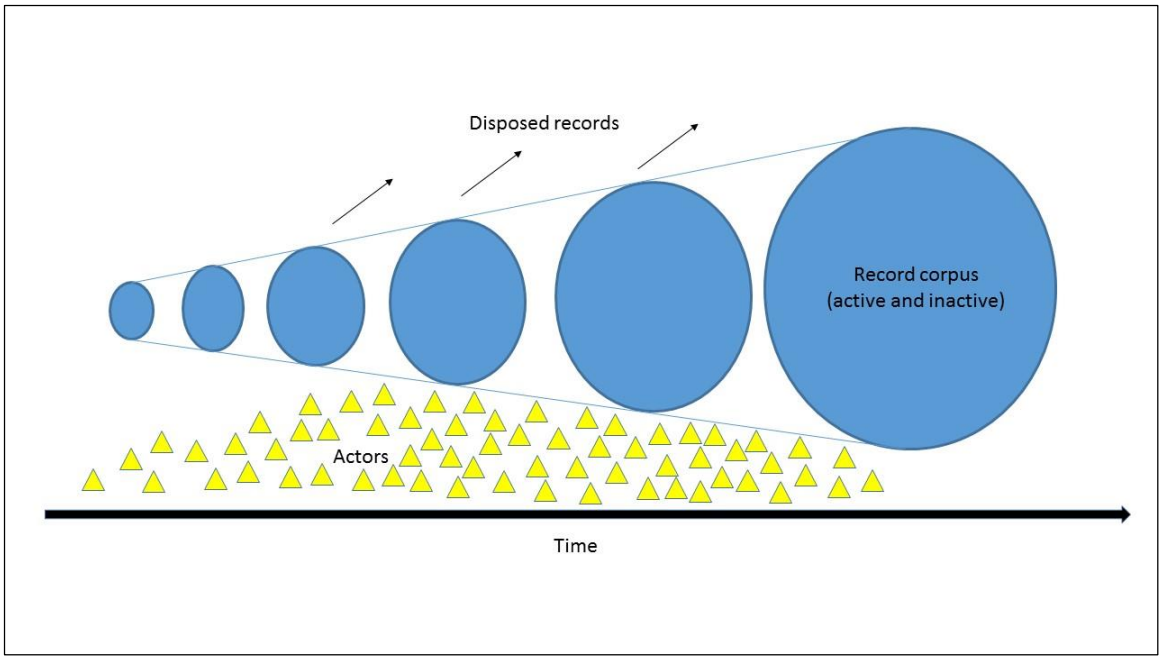

Figure 1: LPH recordkeeping ecology over time. The blue circles represent the corpus of hospital records as it grows over time due to the production (and reproduction) of more records over the course of the hospital's existence. The yellow triangles represent human actors who interact with one or more of the records during a single point or span of time.

Ecology's etymological roots are in 19th-century biology, as a branch of the field that studies the relationships between living organisms and their environments. It can also refer to the relationships themselves. In 1908, ecology was used for the first time in a sociological sense of studying "the relationships between people, social groups, and their environment" (Oxford English Dictionary, 2008). Like the biological definition, ecology can refer to "the interrelationship between any system and its environment" or the product of such a formation. Bonnie Nardi and Vicki O'Day (1999) define an information ecology as "a system of people, practices, values, and technologies in a particular local environment." Critics of Nardi and O'Day's conceptualization of information ecologies have problematized the use of a biological metaphor. Most notably, the authors fail to recognize the power dynamics over time in organizational ecologies (Selfe and Hayden,

2000; Bowker, 2001) and the situated agencies of non-human actors (Hart-Davidson, 2000; Ranney, 2000).

The Chicago school of sociological thought originated the concept of investigating human ecologies, or the relationships of an individual with her environment, in order to contextualize human understanding within a "social (and often geographic) space and social time. […] Every social fact is situated, surrounded by other contextual facts and brought into being by a process relating it to *past contexts*" (Abbott, 1997, p. 1152, italics mine). Numerous studies have already posited hospital records as an integral part of institutional culture (Craig, 1989, 1990; Ngin, 1994; Yakel, 2001a, 2001b; Mol, 2002). I intend to extend these investigations by analyzing the role of mental institution records as contributors to institutional culture framed within specific historical periods and settings. Furthermore, in the case where hospital records continue to exist beyond their original purpose or even the "life" of an institution, I will explore how they may acquire broader cultural purposes. Such an analysis will necessarily include an examination of whether legacy mental health records can or should be preserved as cultural heritage to be accessed by anyone other than the health care providers and their patients and immediate family.

RESEARCH QUESTIONS

My research questions address the uncertainties regarding the location and functions of mental institution records within two interrelated heritage frameworks, that of the creating institution and of a broader cultural community. The questions are framed by the temporal characteristic of records and their ability to exist in multiple ecologies simultaneously and sequentially. In terms of putting this research into practice, it is my intent that this work provide further insight for the archival and medical communities into whether and how to preserve and provide access to collections of sensitive documents. More broadly, this research examines the peripheries of what we can call our "cultural

heritage" and the tenuous social implications of opening what has historically been closed.

First, how have the historical records of LPH contributed to the cultural life of the hospital? With this question, I address:

- What role did the records play in the daily work practices of the nursing staff?
- What power inequities are reflected in the records? Have the records perpetuated these inequities, and if so, how?

Second, how can the records contribute to the cultural life of a broader audience now? In order to understand the potential impact of the hospital records on various communities, I focus on the following questions:

- What stakeholders, social relationships, and historical circumstances will affect record preservation, record access, and potential communities of users?
- What are the ongoing values of these records, especially given privacy restrictions and limitations of what the records alone can tell us?
- What role do archivists play in addressing power inequities?

My objective with this set of research questions is to identify the discourses that are part of quotidian recordkeeping practices, and how records discursively connect individuals such as staff members and patients. By examining historical social disparities, dialogues, and negotiations between stakeholders that are present in the records and confirmed by interview participants, I can better understand how and why archival mental health records as historical objects affect modern day stakeholders both positively and negatively. Beyond illustrating the ongoing inequities that the archival records represent, my research serves as the basis for developing alternative arrangements and uses for the records that can mitigate historical inequities while upholding current privacy laws and

respecting the longstanding relationships between the records and institutional stakeholders.

In the next section, I will introduce my research site, Larch Point Hospital, and my experience becoming familiar with the institution, the records, its administration, and staff. My role as a project archivist for the hospital is the primary impetus for the access I have had to the hospital's records and personnel for my dissertation research. Therefore, I will discuss in detail how my dual roles of project archivist and academic researcher emerged and informed each other over the past several years. I will describe my interactions with the records as an archival practitioner since I am seeking, in part, to better understand the reflective process archivists must engage in in order to manage hospital records. In addition, I will explain the progression of my relationships with key hospital stakeholders, which not only determined the manner in which I conducted my dissertation research but also proved to be research data by providing insight into the hospital administration's concerns regarding opening its archives and allowing me, as a researcher, to talk to their employees.

OVERVIEW OF RESEARCH SITE AND MY ROLES

Larch Point Hospital (LPH) is a state-funded mental health facility located in the American South. Encouraged by the federal government agency, the Freedmen's Bureau, the state created the facility at the end of the Civil War to specifically serve as an asylum for African Americans. LPH was located originally in a former Confederate hospital, and in the mid-1880s, it relocated to its current location on a former Civil War battleground. In 1894, based on my findings in the board meeting minutes, the hospital's name changed from being a "Lunatic Asylum" for "Colored" people to simply Larch Point Hospital. The hospital ran as a "separate but equal" state facility until the advent of the Civil Rights

Act of 1964, after which the hospital was desegregated. The hospital continues to serve the area and has a mix of civil and forensic patients.[2]

My involvement at my research site began in the winter of 2009-2010. I initially heard about the archival/preservation project though my committee chair, Dr. Patricia Galloway who, though Dr. David Gracy II, was contacted by Dr. King Davis. Dr. Davis is now an emeritus professor at the School of Social Work and former director of the Warfield Center for African and African American Studies at the University of Texas at Austin (UT). He has several years of experience overseeing state hospitals in the South, and, since the 1990s, has had a continued interest in the preservation of the historical, or legacy, medical records from the first hundred years of LPH. Dr. Davis believes that the records can provide much needed information about the development of African American health care, including medical perceptions of race, experimental treatments, and policy implementations. He received a federal grant to form a multidisciplinary team from UT to begin a records preservation and archives project for LPH. After contacting Dr. Davis, we came to the agreement that I would be the archivist who would process the existing collection at the hospital and prepare the materials for digitization. The current team also includes Dr. Galloway; Dr. Unmil Karadkar, also of the School of Information; and Dr. Celeste Henery, a post-doctoral anthropologist at the Warfield Center.

The final deliverables for the archives project from the start have been experimental and flexible due to uncertainty about funding, legal restrictions, and the fluid and complex stakeholder relationships. However, the two overarching goals have remained the same: preservation and access to the entire collection by the staff and to subsets of the collection by researchers and the public. All of the records that are part of the archival collection are inactive medical records and are no longer used in the treatment and care of patients. They are not used in the daily administrative work of the

[2] "Forensic" in this context refers to a legal classification of person who is deemed by the court to be either mentally unfit for trial or is not guilty by reason of insanity and ordered to serve time at a mental facility.

hospital, except as resources for the hospital's information release coordinator who addresses inquiries primarily from lawyers and descendants about former patients. Preservation was the primary concern in the beginning of the project, spurred on by several administrative staff members believing that at least a portion of the inactive records would be destroyed according to the state's record retention and disposition schedule; later, I would discover that this belief was rooted primarily in cross-institutional miscommunication and underdeveloped workflows for transitioning records to archival custodianship. As part of the project's preservation goals, it was imperative for the records to be physically preserved and digitized. The latter effort would help ensure that the records' textual information would be saved even if the physical documents were somehow lost, destroyed, or deteriorated. Digitization was also a potential way to provide greater access to various communities of existing and emergent record users. The project team was aware from the start that digital access to mental health records by the public was almost unheard of in the United States because of limited state funding for digitization, the privacy restrictions imposed by HIPAA, and the increased legal liability to record-holding agencies when they offer access to collections that contain sensitive personal information. Nevertheless, Dr. Davis and the rest of the project team pushed forward with digitization because of the belief that, firstly, the underutilized collection has untapped cultural and intellectual value, and, secondly, the digitization effort was a worthy academic case study of the ethical and technological challenges of making information from formerly closed records electronically available to different groups of people.

In the summer of 2010, I spent two months working full-time at the hospital in order to process the collection, which involved making preservation, appraisal, arrangement, and metadata description decisions. Processing is an archival activity in which an archivist aims to gain "intellectual control" over a collection of records by physically organizing the materials and creating a document called a finding aid to allow future patrons to know what records are there and to help them locate information. The

archivist typically groups records in an institutional collection according to the different organizational activities that they helped facilitate. Processing also involves writing a description of the organization, its structure and its history. Finally, the archivist is in charge of ensuring the collection is properly preserved and housed for long-term access and use. For the LPH collection, I conducted basic preservation and conservation tasks such as surface cleaning of documents, humidification, and document housing.

In the archival field, when faced with a seemingly insurmountable backlog of records that need to be processed – a common problem in big and complex organizations such as government agencies that produce large quantities of records – many archivists turn to the archival paradigm of Mark Greene's "More Product, Less Process," or simply MPLP (Boles and Greene, 1996; Greene, 2002; Greene and Meissner, 2005). MPLP calls for archivists to accept that item-level processing is not always possible and is not always essential for archival access. In practice, archivists have been employing some variation or elements of MPLP before Greene gave it a name. It is an archival concept that I believe is important and often necessary, but for the LPH archives collection, I quickly realized that implementing MPLP would not meet the needs of the LPH project's digitization component. Digitization of archival collections does not require the handling of every document, but for this particular project, assessment of individual items was necessary for two reasons. Firstly, by physically and intellectually working with each record, I could identify duplicates and thus prevent redundant scanning. Secondly, I wanted to label each document with a unique identification number and collect descriptive and physical metadata from the object that can be linked with its digital surrogate.

As the archivist for the LPH project, I oversaw one Master's LIS student, who happened to be Dr. Davis' daughter, Halima. Halima and I worked on the collection in the Medical Records Department. The collection, other than the patient admission registers, had been housed in the "Old Library" but had been moved prior to my arrival. At the time, all of the staff members who worked in the Medical Records Department

were female. The length of time that they had worked there appeared to vary from a few years to several decades. At least one was a nurse who had been injured while working with a patient and was working temporarily with the records. The staff members were accustomed to the patient admission register being housed in their department, with some displayed on top of a low cabinet. According to some staff members, the registers were occasionally used by the hospital doctors to show old diagnoses and recordkeeping practices to their medical students. The staff members had been prepared for Halima and my arrival by the administration and Dr. Davis. Some were curious about what we were doing and the materials themselves. The senior staff members were particularly interested in the hospital photographs from the 1950s and onward because they recognized colleagues in them.

In addition to the preservation, conservation, and archival work that summer, I also met with several former staff members during group luncheons at the hospital. The two luncheons were organized by an individual whom I am calling Robert L., a retired staff member whose former position allowed him to know many employees, and Dennis H., a doctor and administrator. Both men have an abiding interest in the preservation of the archival collection and documenting the hospital's history. The so-called "old timer's" event was an opportunity for me to identify possible interviewees, to video record the staff members reminiscing about their time at the hospital, and to show them archival photographs, in which they identified staff members and recollected stories connected to the images. Since I had not sought out Institutional Review Board (IRB) approval for these informal conversations, I do not use the recorded discussions as part of my dissertation dataset.

My preservation and archival background, as well as my general interest in historical scholarship, guided how I approach the dissertation research and especially how I initially perceived the potential value of the archival LPH collection. I began my research from the perspective that the hospital's records could become part of the material evidence that supports public history, serve as the impetus for dialogues among

community groups, or be used for commemorative purposes to remember the people and places that these materials arose from or recorded. Therefore, I strongly felt that all of the historical records – in the many ways that "historical" can be defined – and any additional records such as oral narratives and artifacts should be preserved. While I knew that the federal Privacy Rule (2002) at the time prevented researchers and relatives from gaining easy access to the records, I felt certain that the documents should be preserved for the indefinite future, especially given that the collection might be moved to the state archives. The archives has an access policy that allows patrons to view documents containing patient information 75 years after the creation date of the record.

My ability to have access to the LPH collection as a researcher is a privilege. I recognize the potential controversy in making these records available, as I am acutely aware of the violence and racism depicted in the records. The collection represents a complicated institutional history and has the potential to be the linchpin for exacerbating any ongoing tenuous relationships among the records' stakeholders, e.g., the hospital, the state mental health department, the state archives, patients' relatives. In the next section, I will describe my interactions with the hospital administration in order to gain their approval for my continued access to the archival collection as a scholar rather than a practitioner and to speak on the record with the hospital's staff.

NEGOTIATIONS TO GAIN ENTRY INTO THE FIELD

I submitted my IRB application at the beginning of 2013 for the interviews I planned to conduct with hospital staff and scholars. While it is not mandatory to have IRB permission to conduct and use interviews for scholarly research, I wanted to ensure that I had carried out my research in a way that not only met my own ethical standards, but also that of an ethics board. In order to receive IRB approval, I needed endorsement letters from any institutions besides UT that are involved in my research. I was eager to get the official approval from the LPH research review committee to interview some of their former and current staff members.

The negotiation with the LPH research review committee was a seven-month process from January 2013 to July 2013. It was a lengthier and more emotionally challenging process than I had anticipated. This dialogic work helped me better understand the difficulties of communication across disciplines. The committee, which is composed of a group of four LPH doctors, meets once a month to discuss how to ensure the greatest quality of care at the hospital. The communication was primarily through email, in which the committee conveyed changes they wanted to see in my research proposal. The rounds of edits continued to be inconclusive until the board and I finally spoke over the phone in May 2013.

From the phone conversation, it became apparent to me that the current hospital administration had not encountered many, if any, researchers who were requesting access to their archival records for non-medical research purposes. There were two main themes that ran throughout the conversation. First, the committee emphasized repeatedly that they were unfamiliar with qualitative research and wanted to understand it better. Their comments helped me realize that I had written my proposal as if addressing an academic, social science audience, e.g., an IRB; I was not proposing a research agenda that would convince a board of medical doctors. In the conversation, I clarified the connection between my examination of the LPH records with my interviews, and why it was important I look at both, even if the people I will be talking to are not the ones who produced the records that I am looking at. Because I am not conducting a quantitative analysis, they wanted to know how I intended to examine my data. I explained critical discourse analysis and open coding. The committee was very interested in these qualitative methods and wanted to know more.

Second, the committee expressed concern about my access to the records. They wanted to distinguish between my access to the materials as the project archivist and as a researcher. Legally, my ongoing access to the records as both the project archivist and as a scholar is unclear because the records themselves are in a transitional stage between the hospital and the archives. The status of my access is very much dependent on the

custodial status of the records. As the archivist for the LPH project, my drive to preserve the records for future access is tempered by the immediate necessity to view them. In addition to the need to handle and view the materials, I now have learned about patients from the records that inform my scholarly research about record formats and the role of records in mediating relationships at the hospital. While I have no intention of publishing any private health information, my knowledge of the archival collection without access restrictions, for better or worse, is a factor in my research trajectory.

One member of the hospital's research committee wanted me to tell the committee unambiguously whether I was asking permission from them to have access to individual case files as a researcher; I told them I was not. I emphasized to the committee that maintaining patients' and staff members' privacy and confidentiality is of utmost importance to me, and that I will not be using any restricted personal information from the interviews or from the written records in my research. Rather, my focus is on how recordkeeping practices and record formats change over time, and situating these changes within larger socio-historical contexts. Nevertheless, I sensed a wariness from some of the committee members about my intentions and the impact that my research could have on the hospital in terms of public response and the potential to expose personally identifiable information. I think of my dissertation research as being highly situated and therefore relatively narrow in terms of content and context, but I do think it is also serving as a catalyst to much larger issues of historical accountability, institutional presence, and the power of records.

Throughout my interactions with the hospital and its records, I have been acutely aware of the risk of using resources and trusted relationships for scholarly advantage. Archivists have long been considering their dual roles as archivist scholars (Danielson and Eppard, 2013). While I view my privileged access to the LPH collection as an integral part of my role as project archivist, I understand my access as a scholar carries the risk of becoming problematic. Therefore, for every action I take for my dissertation, I ask myself if I am taking advantage of my relationship with the hospital staff and the

records. Do I feel as if I may be betraying the hospital's trust in me as the project archivist? If the answer is "yes" to those questions, then I do not proceed. As part of my agreement with the hospital, I do not disclose the name of the hospital in my dissertation or any related publications and presentations. In addition, all interview participants are provided pseudonyms. In order to honor the hospital's request for non-disclosure, I have also chosen to excise the names of any administrative and medical staff that appear in my dataset from the archival records.

I would like to have given each of my interviewees the choice of whether to use her own real name or be provided a pseudonym in the dissertation. It would have been part of the collaborative process that I had envisioned initially, in which the interviewees would help shape the direction of the research and have power over their stories. Furthermore, in many cases, I was "interviewing up" – the people I spoke with were administrators, medical doctors, etc. who hold authority at the hospital and over my ability to conduct research there. As with oral histories, I believe a number of my interviewees would have wanted to be recognized for their work, much of which had never been recognized formally outside of the hospital environment. Ultimately, though, I believe that agreeing to provide anonymity to the interviewees through pseudonyms was the appropriate choice given the hospital's ongoing role in the community. We only have to be reminded of cautionary cases such as the Boston College Belfast Project, which has served as a warning to oral historians about the challenges of maintaining trust and confidentiality in the face of the law.[3] Since laws are subject to change, it is critical that

[3] The Belfast case involved interviews of former Irish Republican Army members conducted under the auspices of anonymity, but the British government has been successful in requiring the anonymity to be lifted in order to investigate crimes that were committed during the lengthy Ireland-U.K. conflict known as the Troubles. It is important to note that the coordinators for the Belfast Project did not seek IRB approval; if they had done so and met the constraints placed by the IRB, they would have approached the interview process differently, especially in terms of seeking informed consent. More information on the inability of oral historians to guarantee confidentiality can be found at https://networks.h-net.org/node/16738/discussions/37161/statement-oral-history-network-ireland-boston-college-belfast

interviewees are made aware of the possibility of losing anonymity before they give their so-called "informed consent."

After the seven months of negotiation with LPH, I came to an agreement with the hospital director and hospital research review committee. Once I finally received authorization from the hospital research review committee, I quickly received approval from the Institutional Review Board for an expedited study, 2012-12-0089, in July 2013. In July 2014, I renewed my IRB approval for one more year.

POTENTIAL IMPACT OF RESEARCH

Prior to my data collection and analysis, I was already aware of some potential impacts of this dissertation research, and I had these goals in mind from the start. First, while working on the LPH project, it was evident that the staff and administration might benefit from the hospital's archival records serving as a starting point for a deeper understanding and appreciation of the hospital's history. Heritage development for the hospital could raise awareness and discussion about the historical racial tensions that the hospital and its records embody for some, and encourage dialogue that acknowledges social inequities in the past in order to focus on reconciliatory actions in the present.

Another possible outcome of my research is that I will be able to develop a set of recommendations based on my findings that could help guide other institutions who are managing sensitive health records and want to utilize the records beyond their intended use but are concerned about the legal, ethical, and technological limitations. As a mental health care institution in the U.S., LPH has a unique historical background. The questions that I seek to answer through my dissertation research are not site-specific, but my dataset and results are particular to the hospital and dependent on its historical context, record ecologies, and stakeholder networks. The intent is that this research be the basis for future comparisons with other state mental facilities. It is my hope that the concluding recommendations, grounded in my analysis of the LPH dataset, can be extrapolated to the

management of sensitive records at other institutions, but only after considering the unique ecologies and circumstances of those facilities.

Finally, I also intend to use my dissertation research to encourage the multiple stakeholders who are in positions of power regarding what happens to hospital records to consider the many stakeholders involved in mental health records, including their creators and the patients. I present the social lives of records and the records' enduring cultural impact by showing the discursive actions of records both while in use for medical use and afterward; this information about the ongoing risks and potential value of inactive records can have great implications for how they are preserved and accessed. Therefore, archivists, as well as historians, should take a larger role in the shaping of laws, rules, and policies regarding medical records by sharing their professional expertise on historical materials as well as their ethical stances toward patients' privacy. By demonstrating that mental health records have social ecologies that are far-reaching and always in flux, I hope to influence politicians and medical administrators in their perceptions, rhetoric, and decision-making regarding records' persistent mediation within social relationships.

Chapter 2: Literature Review

My dissertation research, which is focused on a complex social environment with a diverse group of stakeholders and human and non-human participants, is couched in multiple fields of inquiry. I have identified four bodies of literature that intersect in my study, and I have reviewed them in order to provide myself a broad contextualizing framework in which the research site and its records reside. The first group of texts that I examined pertain to the legal aspects of medical record use, especially the state and federal laws that records managers and archivists must abide by when creating preservation and access policies for patient records. The second set of literature is the work of sociologists who have developed Actor-Network Theory. I approach this study from the standpoint that objects such as records have social lives and can have impact as mediators in social situations. In my review, I focus on sociology research that examines institutional records, and especially clinical records, as integral actants within information ecologies and organizational workflows. The third area of relevant scholarship is the history of medicine, namely the development of psychiatry as a profession in the U.S. and its relationship with the rise and fall of the American mental institution. Since my research site was for a hundred years an institution that solely served African Americans, the history of African American mental health care is especially pertinent. Finally, the fourth field is archival studies and, in particular, the ongoing inquiry into the management and use of official records as they traverse from their original institutional purposes to holding archival status. The question of archival responsibilities toward institutional health records is an integral part of this dissertation research. Although not specifically addressing the archival management of hospital records, previous research by archival studies scholars offer some insight into how archivists have become activists in defining archives-building, archival communities, and access to sensitive records according to social positions.

LEGAL: U.S. MEDICAL RECORDS, PRIVACY, AND ARCHIVES

Health Insurance Portability and Accountability Act

For thousands of years, the Hippocratic Oath has represented the guiding principle among Western health care providers to protect the privacy of their patients: "Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private" (North, 2002). Such trust is necessary in order for people to confide in their doctors without the fear that they will be ostracized for their medical conditions. The security of health information has become increasingly challenging with the advent of multiple health care providers, third-party companies, and national digital infrastructures that make the movement of such information highly fluid and prone to unauthorized access.

The United States' Health Insurance Portability and Accountability Act of 1996, or HIPAA, and the Department of Health and Human Services' (HSS) Privacy Rule (2002) were both created to address the growing risk of health information breaches by identifying responsible parties and defining protected information. These federal policy instruments, however, have had unintended consequences for scholarly researchers and the archival field. Congress passed HIPAA primarily to protect people from being denied health insurance benefits when they change jobs. Benefits received for a health problem in a prior job would continue in the new job despite the pre-existing condition. HIPAA was also intended to increase and improve the electronic transmission of health care information. Improvements included greater protection of patients' privacy.[4] The ability to transfer patients' information electronically across state lines to multiparty providers

[4] Contemporary policy discussions regarding privacy in the U.S. began in 1890, when Samuel Warren and Louis Brandeis wrote "The Right to Privacy" in *The Harvard Law Review* partially in response to new photographic technologies that they believed allowed newspapers "to take pictures surreptitiously" (p. 211). As a result of their advocacy, states began passing privacy laws.

and third parties has made it necessary for federal agencies to become involved in health care information regulations.[5]

In order to meet HIPAA's requirement for the establishment of national rules regarding the dissemination and use of health care information, the HHS Secretary issued the final version of the "Standards for Privacy of Individually Identifiable Information," or the Privacy Rule for short, in 2002. The main concern of the Privacy Rule is to protect the privacy and confidentiality of patients from unauthorized people, processes, and the public at large. The Rule, however, does not define "privacy." In William Prosser's (1960) discussion on privacy tort law, part of his description of privacy includes the shielding of information from public view that may be "offensive and objectionable to a reasonable man of ordinary sensibilities" (p. 396) or "not a matter of legitimate public concern" (p. 417). These two conceptions of privacy speak to ethical and legal standards, respectively, that view various types of sensitive information or knowledge as under the control of an individual and disclosed only upon the information holder's consent. Daniel Solove (2006) modifies Prosser's views on privacy by arguing it is not just an individual right but a social one. He posits, "Constitutive privacy understands privacy harms as extending beyond the 'mental pain and distress' caused to particular individuals; privacy harms affect the nature of society and impede individual activities that contribute to the greater social good" (p. 488). Solove suggests that identification can negatively affect identity by attaching "information baggage to people" (p. 513) and ending anonymity; he emphasizes that it is not just the recorded individual at risk but all people associated with that individual.

The Privacy Rule, however, does define "confidentiality." It is the assurance that "data or information is not made available or disclosed to unauthorized persons or

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[5] For an example of breached medical privacy, see Sack (2011), in which he describes how electronic records containing emergency room information for 20,000 patients at Stanford Hospital in Palo Alto, CA, was available on the Web for a year.

processes" (Lawrence, 2007, p. 430). In discussions of HIPAA, the terms "privacy" and "confidentiality" are often conflated, but it is the latter that is used most often in state laws (Petrila, 2000). The confidentiality of individuals is protected under law to preserve both their privacy and their autonomy to decide if they want to seek medical treatment. It is also to encourage a relationship of trust between patients and their doctors, as well as reduce the potential for stigma that patients might face.

The regulations imposed by the Privacy Rule apply only to what are known as "covered entities." These are people, businesses, or agencies that provide, bill, or receive medical care payment. Importantly, such entities must also transmit protected health information that has already been saved in an electronic storage medium. As a result, as Lawrence (2007) points out, hospitals and other medical facilities that closed without ever utilizing computers for storing or transmitting health information are exempt from the Privacy Rule. However, if non-electronic records are held in what is otherwise a covered entity, then they fall under HIPAA and its accompanying regulations. There is also a category called "hybrid entities," namely medical universities that fall under both covered (hospitals) and non-covered (academic departments) jurisdictions. The degree of required HIPAA compliance for state and university libraries/archives that are hybrid entities remains imprecise, as it is dependent upon their relationship with other government branches and university hospitals, respectively (Novak, 2005). The privacy status of information depends on where the documents, or more ambiguously, where the digital files, reside. Therefore, a scenario is possible in which a digital file located in a university hospital would be protected under HIPAA, while a copy of the same file housed in the school's adjacent archives would be available to researchers. Access to the latter item depends on the archives' access policies, which may or may not follow the Privacy Rule.

Covered entities are responsible for protecting all individually identifiable health information (IIHI). Under HIPAA, any IIHI possessed by covered entities is private health information (PHI). PHI must meet three criteria: the items must be created or

received by health care providers, they must be about the condition or health care of an individual, and they must be detailed enough so that the individual can be identified. PHI can be information pertaining to those no longer living. Crucially, under the Privacy Rule, access restrictions were applicable retroactively to non-active IIHI as long as that information was in the possession of a covered entity. Legally, it did not matter what was historically considered public information or without social stigma. The Privacy Rule, according to Lawrence (2007), was the first major regulation to apply in perpetuity to information pertaining to the deceased. Prior to HIPAA, "postmortem privacy" had been discussed only in terms of genetic data (p. 437). With the HIPAA Privacy Rule of 2002, information about the living and the deceased were treated the same. For the latter, information restrictions were for the sake of descendants, who could face a range of potential social (e.g., mental institutionalization) and economic stigmata, such as biased health insurance evaluations if potentially damaging genetic information about their ancestors is revealed.

Unlike past privacy protection initiatives, HIPAA also places access restrictions on information and not just records. Therefore, any type of record could contain protected information. This redefinition of privacy in the health care system complicates research and projects that seek to gain access to and/or publicize records that may have a direct or only a tangential relation to medical information. In particular, the privacy protections have made it challenging for historians, medical anthropologists, genealogists, and others to gain access to health care records. Such historical records could be useful as diagnostic case studies, longitudinal epidemiological data, family medical histories, and insight into institutional and medical practices. Prior to the changes in to the Privacy Rule in 2013, the regulation required researchers who sought to gain access and use of any PHI in medical records to receive waivers of authorization from either an IRB or a Privacy Board. Developed by HHS, Privacy Boards have at least two members who do not have conflicting interests with any of the parties involved in the request. The covered entity is responsible for determining if the board is satisfactory. According to the Department of

Health and Human Services (2003), the boards grant such waivers only if the board members deem the research to be impossible without access to the PHI *and* the proposed research posed minimal risk to the privacy of individuals. The Privacy Rule before 2013 was arguably overly broad, especially because the law applied in perpetuity both into the future and retroactively, and did not adequately address the social and temporal complexities of records within the medical institution system.

Modifications to the Privacy Rule

Legislation and regulatory law are culturally-inscribed and subject to change. For example, in 2011, the federal government was considering strengthening the protections for research that may "pose informational risks" (Dept. of Health and Human Services, 2011, p. 44,526) by adopting HIPAA-level restrictions for information in non-covered entities, including state archives. In the Department of Health and Human Services' July 2011 proposal, "Human Subjects Research Protections: Enhancing Protections for Research Subjects and Reducing Burden, Delay, and Ambiguity for Investigators," HHS states:

> We are considering adopting the HIPAA standards for purposes of the Common Rule regarding what constitutes individually identifiable information, a limited data set, and deidentified information, in order to address inconsistencies regarding these definitions and concepts between the HIPAA Privacy Rule and the Common Rule. Furthermore, in light of emerging technologies and evolving informational risks, it might be advisable to evaluate the set of identifiers that must be removed for a data set to be considered "de-identified" under both human subjects regulations and the HIPAA Privacy Rule. (p. 44,525)

The Common Rule, or the Federal Policy for the Protection of Human Subjects, is a set of regulations by several federal agencies and departments, and includes the HHS' Common Rule (1991), which outlines how living human research subjects are protected (e.g., Institutional Review Boards). Thus, any IIHI could potentially be treated as PHI, regardless of the record's location.

A number of groups, including the Oral History Association, the American History Association, and the Society of American Archivists' Privacy and Confidentiality Roundtable (SAA) came out against the proposed rulemakings. In a letter to the Director of HHS, SAA president Gregor Trinkaus-Randall (2011) maintains that "our profession believes that only the narrowest set of material should be subject to access restrictions and that even necessary restrictions should not exist into perpetuity," and suggests that medical information should not be restricted more than "two generations." Trinkaus-Randall emphasizes the archivist's role in historical inquiry, as well as the core values and code of ethics developed by SAA.[6] Problematically, both HHS and the opponents to the proposed privacy restrictions lacked granularity in their arguments. They did not distinguish between the varying levels of control and agency of individuals over their records, whether the records are oral histories, historical medical documents, or part of creator-donated personal collections.

The proposed July 2011 amendments were not adopted. Instead, HHS modified the Privacy Rule in response to research professionals including archivists and historians who "expressed frustrations" in regard to access limitations to medical records – sometimes centuries old – because they contained identifiable health information (cf., Novak, 2005). As a compromise between the ethical need to protect the privacy of patients' descendants and the potential research value of inactive medical records, the Privacy Rule now classifies the IIHI of individuals who have been deceased for more than 50 years as *not* being protected health information even if the records are held by a covered entity. The decision, which went into effect on March 26, 2013, acknowledges the capacity for medical records to have multiple values and purposes after they are no longer used for their original purposes. The modified Privacy Rule also violates two major tenets of privacy discourse. First, the record subject must give explicit permission

[6] Cf., http://www2.archivists.org/statements/saa-core-values-statement-and-code-of-ethics

for her information to be used, especially in ways that go beyond the original intended purpose of the recorded information. Second, such use is predicated by the record subject choosing to allow access to and the use of the information rather than the person choosing to *not* permit it. I will address these violations in my recommendations at the conclusion of the dissertation.

The final rule notes that the change to the period of protection for decedent information does not override state laws that provide greater protection of identifiable health information or covered entities that continue to restrict the information because of "professional responsibility" (Dept. of Health and Human Services, 2013, p. 5,614). Therefore, health care information access is determined on a state-by-state and court case basis. As a result, at my research site, there have been no discernable changes in access policies due to the revised Privacy Rule. In contrast, a 1991 amendment to the Texas Health and Safety Code allowed superintendents of care facilities to release personal information about patients (e.g., name, date of birth) to cemeteries and funeral homes, unless the individual or his guardian provided a written protest (Smith, 2005). The amendment also allowed cemeteries to put former patients' information on its grave markers. Subsequently, based on information provided by the Austin State Hospital's maintenance directors, the Austin Genealogical Society has been able to create an online database that lists the graves of the hospital.[7] It includes plot number, name, race, county, date admitted, and date buried.

Preservation of and Access to Legacy Health Care Records

While federal and state laws and regulations were intended to address the privacy concerns concomitant with the adoption of electronic health care information systems,

[7] The database can be found at: http://austintxgensoc.org/cemeteries/austin-state-hospital-cemetery/. Notably, both patients and medical staff are buried in the cemetery, suggesting the hospital community was more communal than it is today.

they have so far added to the legal and ethical complexities of medical-related archivy, research, and digital endeavors. Susan C. Lawrence (2007), a professor of the history of medicine, states, "What constitute 'sensitive' health information and 'social stigma' are not only debatable in the abstract, but are also mutable over time, place, class, gender, life cycle, and a host of other possible variables intertwined with particular historical research projects" (p. 457). There is an ongoing lack of consensus among scholars, lawyers, and archivists how HIPAA and the Privacy Rule apply to historical medical records. Until the Privacy Rule modifications to decedent information in 2013, "no exception permit[ted] ready access to very old records or records already publicly disclosed" (Behrnd-Klodt, 2008, p. 142). While the former are ostensibly available now according to the amended Privacy Rule, "ready access" remains reliant on both state laws and the preservation and archival actions of hospitals and archives. For archives holding historical health care records, there is a spectrum of risk, both in terms of what records should be preserved (and thus take up resources) and what should be made accessible. According to Novak (2005), Head of Archives and Special Collections at Columbia University's Augustus C. Long Health Sciences Library, every archives and library has to create its own access policy to address access to records with PHI: "If every mention of a patient in physicians' correspondence or every photograph of a patient in a hospital bed falls under the definition of PHI, those of us in charge of the nation's history of medicine archives and manuscripts will face an impossible task." For example, Novak points to the Archives of the Johns Hopkins University Medical Institution, which has developed an "incidental disclosures" form to address the unexpected PHI that researchers may find in its materials.

In one of the few court proceedings regarding historical health care information since HIPAA was enacted, the initial judge's ruling echoed the social stigma associated with institutionalization, but the final decision supported public interest and state laws. The dispute was between the Adams County Historical Society and the Hastings Regional Center, a former state psychiatric hospital in Nebraska (Associated Press,

2008). The historical society wanted to identify the nearly 1,000 people who were buried in the hospital cemetery from 1889 to 1957; typical of a state mental institution, the gravestones displayed only the individual identification numbers given to patients by the hospital. In 2008, the historical society filed a suit against the Center, and the district judge ruled in favor of the Center and cited HIPAA as the primary reason for maintaining privacy in perpetuity. An HHS lawyer involved in the case emphasized the negative effect on patients' families if the institutionalization of their relatives was made public. Furthermore, while the public would not have the ability to discover who died at the Center, families of patients could still either look up death certificates or get a court order to see the hospital records. On the other hand, a lawyer for the historical society argued that patients' families would want to know what happened to their relatives, but were stopped by the prohibitive cost of obtaining a court order. The case was appealed and went to the Nebraska Supreme Court, which ruled unanimously in favor of the Adams County Historical Society (Tremaine, n.d.). The Court argued that birth and death records, including burial records, were public under Nebraska's public records statute and therefore exempt from HIPAA. The Hastings Regional Center case is indicative of future disputes among covered entities, HIPAA regulators, public interest groups, and academic researchers. Court cases will continue to be necessary to interpret HIPAA and the Privacy Rule in order to address complex institutional situations such as the one in Nebraska.

State Retention and Disposition Schedules

As we anticipate court decisions to better define the legal landscape of access to and use of patient-related hospital information, state custodians of hospital records remain responsible for continuously determining what and when to retain and destroy these documents. The retention and disposition policies of state-controlled health facilities and archives must address federal and state medical information privacy laws

while obliquely conceding to the practical resource limitations at hand to manage hospital records, e.g., storage space and employees' time. Policies vary from state to state.[8]

Larch Point Hospital is located in a state whose legislature revised its public records act in 2006. Public records are the recorded information that document activities of state agencies, employees, and officers. According to the a publicly accessible guide on the act, any record produced, received, or retained as part of a public business transaction is considered to be a public record. A state facility can destroy records that have been approved for disposal by the state archives, and the two state entities are supposed to work together to develop record retention schedules. The age of the records factors into the determination of what is preserved and what is destroyed: the records retention and disposition schedule for all state administrative records asserts that all pre-1913 materials must be first offered in writing to the state archives. If the archives does not respond in 60 days, then the state agency can destroy the records. Records that were created after 1913, however, are deemed subject to destruction by the creating agency and include contracts, staff meeting files, and schedules of daily activities; the amount of time that the record is stored until it is destroyed depends on the type of document. The opinion of the state agency's records manager is also a major determinant in deciding what is kept and disposed of, as is the case of photographs, audio-visual materials, and correspondence, in which only the "historically significant" ones are to be permanently retained. Meanwhile, other types of records such as board meeting minutes and annual reports are to be retained permanently by the agency or the state archives. Records that were once held by covered entities and were closed due to HIPAA remain inaccessible to

[8] For a state-by-state table on access to "vital records" (e.g., birth certificates, adoption papers), see Appendix II in the 2009 white paper by Records Preservation and Access Committee of the Federation of Genealogical Societies and the National Genealogical Society called, "Open Access to Public Records: A Genealogical Perspective": http://www.fgs.org/rpac/wp-content/uploads/2010/01/00-white-paper-edits-c-final-version4.pdf. In the appendix of *Privacy and Confidentiality in Mental Health Care*, Petrila (2000) presents a table of mental health confidentiality law provisions by state, and indicates if and how access to mental health and substance abuse treatment records can be gained by three stakeholders: the client, her family, and law enforcement.

the public when the records are transferred to the state archives. The records in the archives become available 75 years after their creation dates, which could mean for patients' records, the last entry for that individual (e.g., date of death or discharge). The state archives' policy regarding access to IIHI is more conservative than that of the current federal regulation.

Digital library and archives projects that work with health care records must develop systematic methods of detecting and redacting PHI in order to address the privacy requirements of HIPAA, the Privacy Rule, and state medical records laws. They must also work closely with the covered entities to ensure patients' privacy and confidentiality are maintained at all steps of digitization and content creation. The preservation of, access to, and publication of health care records under HIPAA are still relatively new domains that may eventually be elucidated through further legislative, regulatory, and judicial avenues. Until then, however, the responsibility to interpret the laws to accommodate the continuing use of mental health records remains in the hands of records managers and archivists. My dissertation research will address the power of archivists and other heritage professionals to facilitate access to archival health records within the limitations of the law, and to potentially assist emergent users (e.g., former patients and nurses) of these records in voicing their opinions regarding what information should or should not be kept private.

HISTORY OF MEDICINE: INSTITUTIONAL MENTAL HEALTH CARE

Pinel and Institutional Therapy[9]

Beginning in the 18th century, European scientific communities began to claim that institutional confinement and exclusion from society was beneficial to the mentally ill (Foucault, 2006, p. 337). Perhaps equally significant and more telling of the reasons behind the rise of institutionalization, expansion of the wage-labor system required that the non-able bodied be separated from those who could work so as not to be a financial burden on their communities (Ingleby, 1983, p. 183). Mental institutions supposedly allowed patients to focus on their immediate daily routines and to be industrious without distractions. This attitude toward institutional confinement led to the popularization of mental hospitals in the late 18th and early 19th centuries that adhered to the practices advocated by Philippe Pinel.

Pinel called for the moral treatment and management of patients. He was a member of the Idéologues, an influential 19th-century group of intellectuals that included John Locke, the abbé de Condillac, and Francis Bacon. The Idéologues viewed an individual to be a product of his environment, and so by changing the environment, they could improve society (Weiner, 1990). As a clinician for the poor and the mentally ill, Pinel believed that "normal" behavior could be impressed upon patients if they were kept in a controlled, institutional setting (Grob, 1972, p. 42). It was widely believed that mental problems, such as excessive pride, were moral issues that could be solved through scientific means (Grob, 1972, p. 156; Foucault, 2006, p. 338). Patients had to be isolated from their usual communities; in 1851, the Association of Medical Superintendents of

[9] I have based this section primarily on Grob's three volumes on the history of mental illness in the United States. Grob has been called an asylum apologist by revisionists such as Ingleby (1983) and Scull (1983), who perceive him as downplaying the human rights abuses in 19th-century mental institutions and attempting to revive the reputations of 19th-century lunacy reformers as humanitarians. Grob's critics have suggested that the social policies for the mentally ill of that era were neither accidental nor incremental; rather, they argue such policies were conscious decisions by administrators and legislators. When possible, this section will include other sources in order to provide different viewpoints regarding the history of mental institutions.

American Institutions for the Insane recommended that mental hospitals be located at least two miles from the nearest town (Grob, 1983, p. 166).[10] Through social, political, and economic changes, mental institutions was no longer seen as a place for the mad to go to their deaths, but rather as an important component in the medical treatment for madness; the institution itself became a form of therapy (Foucault, 2006, p. 437). Although mental patients were no longer constantly physically restrained, Michel Foucault criticizes Pinel and other medical doctors of the time for replacing physical chains with social ones; the mad became a social type to be eliminated through a process of "moral synthesis," or repentance, in institutions (p. 479, p. 495). Institutional doctors were not so much medical practitioners, as they were a "moral and juridical guarantee of good faith" (p. 504).

State Hospitals

The Eastern Lunatic Asylum in Williamsburg, Virginia, was the first American hospital that specifically focused on mental illnesses. Its first patient was admitted in 1773. This asylum appears to have been a unique and isolated institution that did not have a strong influence on the administrative structure of the mental institutions that would be built 100 years later. Grob (1983) attributes the rise of public mental institutions in the U.S. during the late 19th century to growing support for community-based welfare for the mentally ill. Others such as Rosenberg (1987) argue that mental hospitals grew out of the general medical community perceiving mental patients to be disruptive to the routines and atmosphere of general hospitals (p. 34). Social control revisionists, however, have argued that the growth of state mental facilities were a part of the State's increasing interest in policing the population through "rational" carceral regimes. They posit that the so-called reformed attitude in the U.S. toward the mentally ill – from a social order threat

[10] The isolation of French mental institutions in the mid-18th century stemmed from the fear that madness was a transmittable contagion (Foucault, 2006, p. 355).

to a subject of humanitarian aid – can be attributed to a broader and "profound shift in moral sensibilities" that also called for poor relief, better crime control, and rejecting slavery, a once "readily defensible institution" (Scull, 1983, pp. 132-133). Prisons and asylums alike became places of surveillance and data collection. Such monitoring enabled disciplinary measures supposedly designed to treat "particular types of deviant in the maps of disorders" (Dandeker, 1990, p. 133).

While local communities supported the care of patients, the hospital buildings themselves were constructed through state government funding. Many were based on Thomas Kirkbride's designs (see Illustration 1), which emphasized how mental institutions were for moral treatment.[11] The architecture reinforced the social hierarchy in which the superintendent was clearly the overseer of the entire hospital and patients were segregated according to their diagnoses (Grob, 1983, p. 225).[12] There is a central building for administration offices and living quarters, lateral patient wings separated by sex, and wards within each wing separated by patient type.

[11] Earlier French efforts at designing correctional facilities include the works of Jacques-Pierre Brissot de Warville and Musquinet de la Pagne. Their architectural plans emphasized geometric and panoptical designs that physically placed occupants according to their criminal statuses (Foucault, 2006, pp. 428-429).

[12] In the same mid- to late-19th-century period, another type of architectural separation was occurring in general hospitals, in which admittance, diagnosis, surgery, and death were no longer taking place in the same ward (Rosenberg, 1987, p. 292). Like mental institutions, general hospitals also began exhibiting clear distinctions of rank and class among the staff, volunteers, and patients through dress codes, treatments, and use of space.

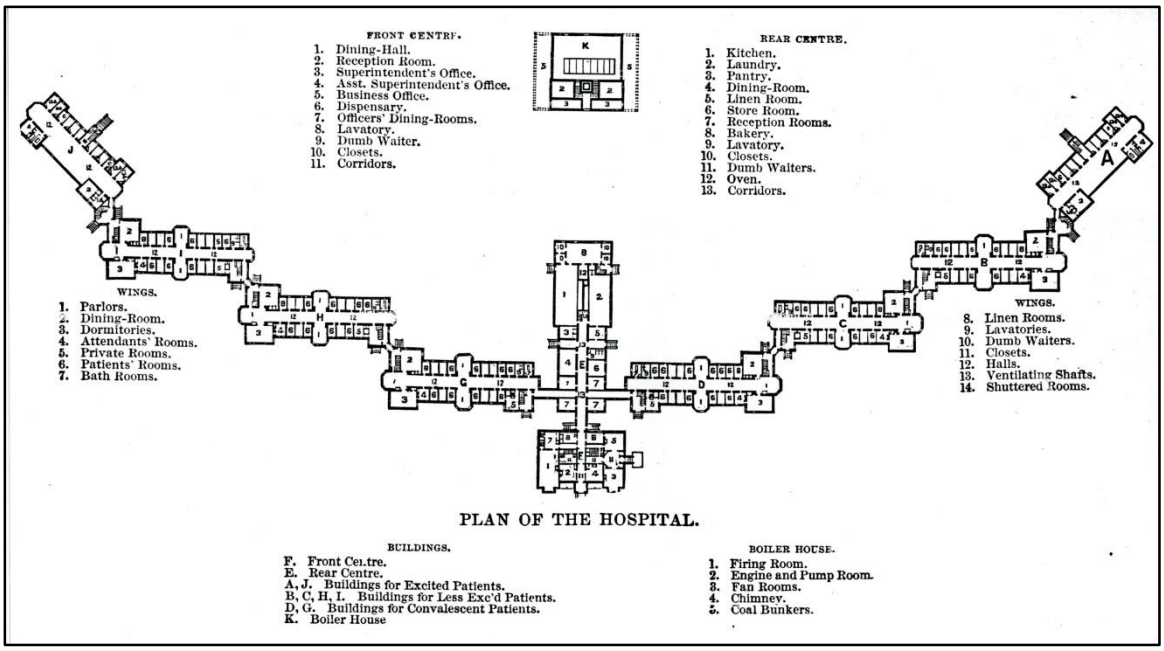

Illustration 1: Kirkbride-inspired design of Danvers State Hospital. Image: Danvers Archival Center.

In the 1860s, a reform movement shifted the responsibility of caring for the mentally ill away from local communities. The mentally ill became the responsibility of the state, in the form of state mental hospital, or welfare, boards (Grob, 1983, p. 272). While these boards grew in prominence, the administrative powers at individual institutions declined. The Southern state boards, however, were particularly weak or non-existent at the end of the 19th century; Grob argues that, as a consequence, these state hospitals had lower quality of care than institutions in other parts of the country (p. 104). Of the Southern states, Virginia had the most comprehensive state hospital system, although centralization was still uneven (p. 214). After 1902, each hospital had a three-person board of directors that was part of a statewide General Hospital Board. In 1922, the State Board of Public Welfare was created. This board gathered reports from each hospital. Grob asserts that the board was relatively ineffectual because it was primarily composed of non-physicians who could be removed at will by the governor. In the 1930s and 1940s, Virginia had some of the lowest average per capita expenditures in the U.S.

for state hospital maintenance, with $177 per patient in 1931 and $189 in 1940 (p. 219). Only North Carolina and Kentucky had lower per capita expenditures. The National Mental Health Act of 1946 ended 42 years of state-only control over mental health care and treatment.

While the early 20th century saw a rise in the number of general hospitals, mental hospitals experienced population growths. Starr (1982) argues that this disparity because of the different function and social status of these hospitals – general hospitals were considered necessary local institutions, and new hospitals were created by religious groups and doctors; meanwhile, mental hospitals were usually state-run and not considered desirable by communities, and there was no incentive for doctors to start their own (p. 169). Handling the large number of patients led institutions to the sorting of patients according to illness. Patient classification became an increasingly prominent part of the admission process (Craig, 1990). In a tangential development in recordkeeping practices, Adolph Meyer developed psychobiology, which emphasized the importance of a patient's life experiences. As a result of his work, patient records began to include a maximally complete history for each patient, called a case file, in one location (Grob, 1983, p. 115).[13]

The Progressive Movement

As psychiatry developed as a profession and distanced itself from the idea of moral management, the role of superintendent became less well-regarded by the field. The emphasis shifted from institutional psychiatry and management toward more "scientific" endeavors such as pathology and the development of medical technologies (Grob, 1983, p. 70). The most influential movement in mental health care at the turn of the century was the mental hygiene movement, which developed out of the rise of public

[13] I discuss the proliferation of records and advancements in classification schemata for psychiatry and mental institutions in greater detail in the next section on sociology literature.

authority, private organizations, and so–called scientific thought.[14] The mental hygiene movement was part of the larger Progressive movement. Those who subscribed to it believed that mental illness came from the environment, heredity, and individual deficiencies, and called for the involuntary sterilization of "defective persons" (p. 109). Other Progressive objectives included the prohibition of alcohol, the prevention of criminal behaviors, immigration restrictions, and the treatment of "abnormal" children and criminals (p. 146).

Eugenics in itself was a broad movement that arose out of Darwinism, and economic and class tensions. State eugenic laws, some of which persisted into the 1970s, called for the involuntary sterilization of the mentally challenged and the mentally ill, criminals, and anyone considered to be "feebleminded" or "promiscuous" (Kessel and Hopper, 2011; Rose, 2011). Young, unwed African American women were often targeted. Interestingly, sterilization was never a national movement because there was no need – there was very little opposition to it; ethical and moral objections to the practice were eventually raised in the U.S. only after the Nazis' use of sterilization during World War II (Grob, 1983, p. 177). State legislation for involuntary sterilization was pushed through by state boards and private organizations in the early 1900s. From 1907 to 1940, there were 18,552 recorded sterilizations in state mental hospitals: California had the most with 9,639 sterilizations during that time period, and Virginia had the second-most with 2,341 (p. 173-174). Seven states thus far have issued apologies to sterilization victims, but none has offered monetary compensation (Rose, 2011).

Institutional psychiatrists experimented with treatments that went beyond custodial care and moral treatments in the period between the world wars. For example, doctors were trying various types of shock therapy (e.g., insulin, Metrazol) on patients

[14] According to Foucault (2006), scientific thought during the age of classicism cultivated the perception of madness as a neutral concept synonymous with unreason and shame (p. 106). He contrasts this era with the earlier Renaissance period in Europe, in which madness was a public affair and insane individuals had the opportunity to redeem themselves (p. 142).

without first having a thorough understanding of how these medications would affect the body (Grob, 1983, p. 296). Patients were the test subjects, often without consent or with little understanding of the potential harm from these experiments. There are documented cases throughout the 1940s through 1960s of federally funded studies at state mental hospitals and prisons to purposely expose patients and prisoners, respectively, to a number of viruses such as the flu, hepatitis, and gonorrhea (Stobbe, 2011). Fever treatment, the intentional infecting of patients with malaria or other kind of fever, was used as a cure for syphilis without any external review for such actions (Grob, 1983, p. 295). Some of the first prefrontal lobotomies were conducted at George Washington University Hospital to treat a variety of ailments from anxiety to insomnia (p. 305). The popularization of lobotomies in state institutions occurred when the treatment was seen as a means to control patients diagnosed with chronic schizophrenia (Grob, 1991, p. 129). The number of psychosurgeries increased from 240 in 1936 to 5,074 in 1949 (p. 130). According to Grob (1983), the data used to justify these therapies lacked "methodological sophistication" (p. 308). Most psychosurgery was replaced by psychotropic drugs, especially Thorazine, by 1954 (Grob, 1991, p. 134).

De-Institutionalization and the Growth of Community Psychiatry

The first instance of the term "deinstitutionalization" occurred in a 1934 report by John Grimes, who worked for the American Medical Association (Grob, 1983, p. 278). He called for a reform movement that would reduce the overcrowding in mental health facilities caused by the closing of almshouses and the aging American population.[15] By 1939, there were 182 state mental hospitals of a total of 557 mental facilities. These state hospitals accounted for nearly 83% of all institutionalized patients, and the majority of these institutions had between 1,500 and 3,000 patients (p. 315). World War II was the

[15] The deinstitutionalization movement is the third of the arguable "psychiatric revolutions," the first being Pinel's work and the second the invention of psychoanalysis (Ingelby, 1983, p. 145).

catalyst for changing the perception and treatment of mental illness; John Appel and Gilbert Beebe (1946) examined the large number of mental disorders occurring among U.S. troops in the field to determine environmental etiologies and to recommend preventive measures. As a result of their study, they developed a continuum theory of health and illness that posited that high risk mental illnesses could be identified early and that treatment could be conducted in a community setting rather than in an institution.

Milieu therapy emerged from the 1950s psychodynamic psychiatry movement, and called for mental institutions to become therapeutic communities by offering patients environmental modifications (Grob, 1991, p. 140). The popularity of milieu therapy and psychotropic drugs led to a growing call for reform of the mental health system and to emphasize therapies conducted in community settings (p. 156). In the 1950s, state governments began to widely support community clinics as short-term alternatives to mental institutions, in part due to popular psychiatric opinion that community clinics were more preventive and humane, and reduced the cost of care (p. 167). The Joint Commission on Mental Illness and Health's 1961 report, *Action for Mental Health*, portrayed mental hospitals as the place where marginalized people were deposited away from the rest of society. The report recommended that no more state mental hospitals with over one thousand beds be built and that the existing ones "be gradually and progressively converted into centers for the long-term and combined care of chronic diseases, including mental illness," as well as aftercare and rehabilitation (p. 206). State and counties hospitals' inpatient populations decreased by 83,720 patients from 1955 to 1965 and by 281,766 patients from 1965 to 1975 (Gronfein, 1985, p. 196).

In 1989, Senator Daniel Patrick Moynihan noted the failure of community mental health centers to serve the public and identified those centers as the cause of the explosion in the homeless population. While Moynihan's statement is an oversimplification of the changes in American mental health care, it does point to the underfunding and understaffing of these centers. Large discrepancies existed between the amount of money authorized, that appropriated, and actual expenditures (Grob, 1991, pp.

250-251). Only 768 centers existed at the time, of 2,400 proposed. Furthermore, the community-based mental health policies were based on the flawed assumption that all mentally ill and disabled individuals would have relatives or other caretakers willing to look after them while being treated in a non-institutional environment.

The African American Mental Institution Experience

African American mental health care has its own historical path that weaves through the general history of mental health care in the U.S., notably influenced by de jure and de facto segregation, and scientific racism. The history is particularly important for situating LPH's institutional development and social ecologies within a national narrative. In late 18th-century Europe and United States, the natural state of "animality" was considered to be the epitome of happiness and tranquility for humans; it was civilization that made people mad (Foucault, 2006, p. 373). Those who had culture, e.g., Caucasians, had to suffer the consequences of remembering their people's history of madness. This was laid in stark contrast to other races considered not to have histories, e.g., Africans. The American physician Benjamin Rush claimed that very few American Indians, or as he called them, "savages," appeared to suffer from madness, and most died of old age and accidents rather than disease (Foucault, 2006, p. 377). A veneer of positivist science gave these racist assumptions the appearance of unbiased truths.

The Western social histories of cancer and mental illness share historical epidemiological views of race. Keith Wailoo (2011), a professor of history and public affairs at Princeton who wrote about the relationship of race and the study of cancer in the 20th century, points out that early cancer researchers were committed to the idea that race was critical to explaining differing rates of cancer. The legacy of physicians and researchers of the late 19th and early 20th centuries believing racial minorities to have immunity to both mental illness and various cancers because of their supposedly less evolved biology is that research, advocacy, and care focusing on non-White populations continue to lag today.

The dominant 19th-century assumptions in the U.S. about the mental health of African Americans, however, differed from those regarding other minorities due to the former's history and socio-economic position in the country. Psychologists of the time claimed that, while supposed uncivilized African tribes were free from mental illness, emancipated African Americans were highly susceptible to mental illnesses. Although an 1840 U.S. census shows a higher percentage of insanity among Blacks in the northern states than in the Southern states, this claim is based on questionable data collection (Gibson and Denby, 2007, p. 5). Nevertheless, the census led to epistemological studies that claimed Blacks became mentally ill when emancipated (Logan 2007, p. 40). Ten years later, Samuel Cartwright, a doctor from the South, proposed two types of insanity specifically characteristic of African Americans, draptomania and dysaesthesia aethiopis (Gibson and Denby, 2007, p. 5). While draptomania was a condition attributed to slaves who attempted to escape, dysaesthesia aethiopis, or "rascality," was applied to all free Blacks who exhibit a "half asleep" quality, destructive behavior, and skin lesions (Cartwright, 1851). Cartwright viewed free Blacks as idle and suffering from "negro liberty," and chides his profession for not paying enough attention to Black illnesses. These diagnoses reveal far more about the prevailing attitude toward the assumed role of Blacks in Southern society than the overall mental health of the African American population.

Prior to the end of the Civil War, most Blacks were denied admission to mental institutions other than in the South (Grob, 1972, p. 245). African Americans who were allowed into mental institutions were placed in segregated wings. An exception can be seen in Virginia's Eastern State Hospital, where John Galt became superintendent in 1841. He accepted both free Blacks and slaves as patients, and did not segregate his patients by race. This integration was an economic decision rather than a social one. Interestingly, all of the hospital servants were slaves. On the other hand, no Blacks, whether free or enslaved, were allowed admission at another Virginian state hospital, Western State. The superintendent at the time, Francis T. Stribling, did not believe there

should be integration of races at a single institution (p. 250). By 1856, slaves were no longer admitted as patients at Eastern State due to public pressures (p. 249).

In Jim Downs' (2012) book, *Sick From Freedom: African-American Illness and Suffering During the Civil War and Reconstruction*, he traces the history of the Freedmen's Bureau and especially its hospital program as a part of the "process of emancipation" (p. 168). According to Downs, a professor of history at Connecticut College, emancipated slaves were without any medical care immediately after the Civil War besides what was provided by the few remaining military camps. The advent of the Freedmen's Bureau led by O.O. Howard and the Freedmen's hospitals led to greater access to health care for African Americans, but President Andrew Johnson and his administration severely restricted the reach of the Freedmen's Bureau for fear that former slaves would become overly dependent on the federal government. As a result, these medical facilities were highly unorganized, underfunded, understaffed, and not perceived as permanent installations. Doctors and other medical staff at the Freedmen's hospitals struggled to fight against disease outbreaks such as cholera, lack of sanitation, and malnutrition. The early hospitals for the emancipated slaves were essentially almshouses in their attempts to provide basic human needs: food and water, clothing, and shelter.

In just a few years after the advent of the Freedmen's Bureau, its hospitals were facing increasing lack of support from their own agency. In order to cut costs, the hospital superintendents used their patients as unpaid labor to grow crops and raised livestock for the institutions.[16] Due to the poor funding of the Freedmen's hospitals, care for the mentally ill was almost non-existent: "Bureau doctors lacked special quarters,

[16] Although the justifications for implementing involuntary farm work by African Americans in Southern hospitals tended to be couched in medicine (e.g., labor as therapy), the agricultural situation nonetheless parallels the "disciplined labor" (Daniel, 1979, p. 93) that took place in Southern prisons after the Civil War. The Thirteenth Amendment, which abolished slavery, allows labor as punishment for convicted individuals. All of the Southern states, whose economies had been reliant on the slave labor system, passed Black Codes after the war that included laws addressing African American vagrancy. Modeled after the antebellum slave codes, the vagrancy laws made being unemployed illegal. Punishment was typically involuntary servitude on prison farms.

floors, or divisions to separate mentally disabled freedpeople from other dependents or from each other; consequently their presence created major problems" (Downs, 2012, p. 149). The practical problems of having general medical care and mental health care in the same facility included the mentally ill causing bodily injury to themselves and others, disturbing the environment, and causing property damage. While the Freedmen's hospitals could not adequately accommodate the mentally ill, many state asylums would not allow African Americans to be admitted despite the passing of an 1866 Civil Rights Act that called for African Americans to have equal access to the public services enjoyed by Caucasians. In order to ameliorate the rising problem of caring for mentally ill, destitute, and elderly African Americans, states created segregated facilities for these populations. Only two Southern hospitals were built specifically for those of African descent, one of which is LPH.

Throughout the period of segregation of all public facilities in the South, the facilities for Blacks, other ethnic minorities, and poor Whites typically were of lower quality than those for wealthy, native-born Whites (Grob, 1972, p. 255). According to early 20th-century records for Washington, D.C.'s St. Elizabeths, the first federally run psychiatric hospital in the U.S., the hospital's board suggested that Black male mental patients be housed with White male criminals (Summers, 2010, p. 82). Underlying this recommendation for classification and segregation was the assumption that Black normality was equivalent to White abnormality, and therefore Black abnormality was in the same category as White criminal insanity (p. 87). Funding in Southern hospitals was allocated along racial lines, whether patients were kept in segregated facilities or separate institutions. For example, in 1907 North Carolina, $155 to $185 was spent per White patient and $111 per Black patient (Grob, 1983, p. 38).

Continuing from the psychological work conducted in the 18th and 19th centuries, a number of prominent psychiatrists throughout the 20th century propounded theories that differentiated between the mental capacities and, consequently, mental health of African Americans and Caucasians. In 1914, the Director of Georgia State Sanatorium suggested

that Blacks in the South were rarely depressed because of their childlike nature; this argument continued through the 1960s, when a psychiatrist linked the supposed rarity of depression among Blacks with the notion that they did not have a sense of responsibility. (Logan, 2007, p. 41). The assumption among some psychiatrists that African Americans were mentally inferior was also used to explain mental illness among Whites. Carl Jung (1930) developed a racial infection theory that was rooted in xenophobic and racial stereotypes. According to Jung's theory, African Americans were responsible for infecting Whites with moral and mental disorders.

It was not until the late 1970s that the psychiatric discourse began looking at differing cultural backgrounds as a factor in how medical staff should examine and treat mental illnesses (Foster, 1990, p. 292). Within the last two decades, the federal government has begun to acknowledge officially that the long history of racial discrimination faced by African Americans has affected their access to high-quality mental health care. A 1999 mental health report from the Surgeon General notes the cumulative power of historical hardships on African Americans' mental health (Logan, 2007, p. 41). A 2003 report from the President's New Freedom Commission on Mental Health suggests that African Americans face social and economic barriers that prevent many from receiving proper mental health care.

The historical records of African American mental patients and mental hospitals have the potential to reveal a great deal about the inequalities and injustices, as well as the instances of kindness and compassion, of Black mental health care. These records, however, are not passive carriers of historical facts or truths. On the contrary, institutional documents (whether at a mental hospital or otherwise) are actants that play an active role in the formation of the organizational structure, routines, workflows, and relationships within an institution. They have the power to sustain or collapse normative practices and beliefs, and, to a great extent, this active characterization of documents has been missing from hospital records in situ or in an archives. Therefore, the next two sections will

explore the interactions of records in an institutional context, particularly that of hospitals and archives.

SOCIOLOGY: INSTITUTIONAL RECORDS CREATION

Defining Institutions

Before discussing institutional recordkeeping and record-creating, it is necessary to define what I mean by "institution," as the term has a rich history and multiple meanings attributed to it. The word "institution" originated in the 14th century to describe the placement of clergymen in specific roles for the Episcopalian Church (*Oxford English Dictionary*, 1989). Since then, the word has taken on non-religious connotations, and moved into broader political and social contexts. An institution can be any established law, custom, practice, or organization that serves a regulative purpose for an organized community or civilization in general. Examples include marriage, a university, and the Catholic Church. In *Governing the Commons* (1990), the political scientist Elinor Ostrom examined what mechanisms must be in place in order for groups of people to successfully share resources. She defines an "institution" as a set of working rules used to determine who is allowed to make decisions, what is and is not allowed, what aggregation rules are used, what procedures to follow, what information is and is not provided, and what payoffs are given to individuals (p. 51). Ostrom's "institution" is a group of regulative principles; it only implies that people create or follow those rules.

The sociologist Erving Goffman (1961) offers another perspective, and defines the concept of an institution in terms of place and social mores (another type of "working rules"). Specifically, he looks at the "total institution" in *Asylum*. He describes it as,

> [A] place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life. (p. xiii)

For Goffman, a total institution is at once a physical place and a set of ideals that classifies and removes a subset of people from the rest of society.[17] It is a hybrid structure of a formal organization and a residential community (p. 12). Those in a total institution, such as an army training camp, prison, convent, or hospital, are required to adhere to a regimented lifestyle, often marked by a lack of privacy or possessions.

During the same period of Goffman's emerging scholarship on total institutions, the first edition of the social theorist Michel Foucault's *History of Madness* was published in 1961. For Foucault (2006), institutions of confinement are tools of segregation, marginalization, and alienation (p. 79). Groups such as lepers, the venereal, and the mad were confined together in mid-17th century France; these communities were in turn categorized together as outcasts because of their shared confinement (p. 86). Foucault's greatest protestation against institutions for the insane was in response to the work of Pinel and 19th-century psychiatry in general, which had naturalized the notion of confinement as the logical treatment for insanity (p. 47). Foucault's asylum is comparable to other communities that appeared fourteen years later in his *Discipline & Punish* and embody Goffman's total institution: the isolated and "marked" leper colony and the disciplined and analyzed 17th-century plague town (Foucault, 1995, p. 198). Information scientists Geoffrey Bowker and Susan Leigh Star (1999) argue that people of all

[17] Peter Sedgwick (1982) argues that Goffman's supposed "final and ultimate paradigms of human existence" (p. 59), e.g., the "total institution," gave the public a dangerous sense of resignation about mental health care. Sedgwick, a leftist activist, believes that mental health care could be revolutionized if focus were placed on the local and the personal needs of psychiatric patients, rather than relying on traditional institutional care. Sedgwick criticizes anti-psychiatry sociologists such as Goffman, Foucault, and Szasz for perpetuating the notion that mental illness is not a "real" illness but entirely socially constructed. He correctly predicted that social conservatives would employ anti-psychiatry theories to justify cutting mental health services, as they did in the UK and the US in the 1980s. Sedgwick's specific criticism that the total institution cannot be the teleological endpoint of humanity is echoed by the broader criticisms of social control revisionists (cf., Cohen and Scull, 1983), who argue that, in the move from liberal to organized capitalism, carceral regimes such as prisons and asylums decline in importance because "*society* itself becomes the disciplinary mechanism" (Dandeker, 1990, p. 145).

hierarchical positions within an institution socialize themselves to reflect the attributions of a given social category or role (p. 230), such as patients, staff, and doctors.

For the purpose of this paper, the institution is considered in a broader sense than Goffman's "total institution," but with a greater emphasis on social structures than Ostrom's "institution." "Institution" will refer to a structured organization of people who carry out a set of rules that is widely accepted by other members of their society, in order to govern both groups of people who are subsets of this society and the entire society itself. Of particular relevance to my dissertation research are institutions such as mental hospitals, prisons, and colonial governments, which oversee groups who are denied much of the agency and rights attributed to the dominant classes and mainstream society, respectively. These institutions create and maintain records about minority communities. I argue that, in turn, the records assist institutional administrators in the governance of minority groups as well as upholding the appearance of organizational stability.

The Production of Power

Next, in order to examine the role of material records on hospital and archival institutions, I will discuss Actor-Network Theory (ANT), which has been the guiding sociological theory for my research in thinking about material agency and the relationship between people and things in an organizational environment. In the early 1980s, Bruno Latour and others such as John Law and Michel Callon at the Centre de Sociologie de l'Innovation developed ANT. Latour (2005) presents ANT as the "sociology of associations," which examines the connections between things that, when alone, are not social (p. 5). The aim of ANT is not to deconstruct hegemonic viewpoints, but instead to reassemble social associations (p. 11). According to ANT, groups (a term which Latour prefers to "communities") are always working to define themselves through continual performance, explanation, and rule-setting (p. 35). Power is not an innate quality, but instead something that must be constantly produced (p. 64). Day-to-day practices are

what create, maintain, and destroy "ontologies," or the multiple and shifting ways in which we enact our realities (Mol, 2002, p. 6).[18]

Perhaps the most important idea for the purpose of this dissertation is that of the *actant*, a term that the ANT developers took and generalized from literary analysis. An actant can be a single individual, an idea, a technology, a biological entity, or a non-biological thing that has agency because it modifies a state of affairs (Latour, 2005, pp. 54, 71). ANT defines all actants as equal participants in a network of associations, and, more specifically, as mediators, meaning they change any associations that pass through them (pp. 34, 39). For the purposes of this dissertation, I refer to human actants as actors, in order to help distinguish their actions from that of records and other objects, or actants. In *Laboratory Life*, Latour and Steve Woolgar (1986) are struck by the pervasiveness of documents in scientific activities, whether the reading, discussion, or production of a "readable trace": "Even the most informal exchanges constantly focussed [sic] on the discussion of documents" (p. 53). They argue that material components are as necessary as intellectual ones for the "production of facts," or the construction of an objective reality, in a laboratory (p. 238). Annemarie Mol (2002) argues that people and objects should be framed together as part of "enacted" practices (p. 44). In his response to ANT, Andrew Pickering (1995) writes of the "dance of agency" between humans and materials (p. 52). This dance is a dialectic of accommodation and resistance in which the former and latter agents rely on each other in order to evolve (p. 58). Pickering disagrees with the semiotic equating of human and material agency by the developers of ANT, however, and argues that in practice people and things are not interchangeable or symmetrical. He instead posits that the performative work done collaboratively by humans and materials is

[18] Cf., Antonio Gramsci's (1971) prison writings from the late 1920s and early 1930s regarding the relationship between man and nature: "[…] one must conceive of a man as a series of active relationships (a process) in which individuality, though perhaps the most important, is not, however, the only element to be taken into account. […] Thus Man does not enter into relations with the natural world just by being himself part of the natural world, but actively, by means of work and technique. Further: these relations are not mechanical. They are active and conscious" (p. 352).

driven by the former's intentionality and practices (p. 17). I, on the other hand, focus on the materials and specifically records as being sites for discursive work that transcends the actions and thoughts of one person in her lifetime.

Several years prior to Latour and his colleagues developing ANT, Foucault (1995; originally 1975), wrote in *Discipline & Punish* about the physical structures of institutions that "operate to transform individuals" in every aspect of the inhabitants' lives (p. 172). If Foucault's prison or hospital was viewed through the lens of ANT, it would be an actant, as "it was, in its very materiality, a therapeutic operator" (p. 172). Foucault also writes about the power of documents, both individually and collectively, to maintain order and hierarchies of power in disciplinary institutions.[19] Thus, along with human actors, documents support the medical field as a professional discipline and the disciplining of patients. According to Weber, files and filing systems make up the internal workings of bureaucracies, and anyone who has internalized these procedures and information to achieve "knowledge of the files" is capable of making optimal bureaucratic decisions (Dandeker, 1990, p. 9). It is the "flows of documents," rather than individuals, that are the "primary mechanisms of managerial control" (Yates, 1989, p. 20). The documents, while created by human agents, have their own effect over time on how institutions run, including the transmission of practices, ideologies, and power. Accumulated data from documents have the ability "to classify, to form categories, to determine averages, to fix norms" (Foucault 1995, p. 190). Written institutional records, whether from colonial or hospital administrations, create identities that are difficult to alter (Mol, 2002). Marc Berg and Bowker (1997) argue that medical records in particular

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[19] In his reflection on *Madness and Civilisation*, Foucault reevaluates his notion of power and suggests it is not a purely negative force, but one that is also capable of producing discourse, knowledge, and even pleasure (Ingleby 1983, p. 179). In her writings on the development of the systematic management movement of the late 19th century, Yates (1989) notes the creation of the in-house magazine as a type of internal communication used to "humanize" a large workplace through the use of shared personal stories, photos, jokes, and cartoons (pp. 17, 74). The magazines indirectly reinforce the management's viewpoint and control over operations.

shape through mediation the way in which we view patients' bodies and collective actors, such as medical institutions and other bodies politic.[20] They are integral to discursive action. John Ernest (2004) writes of the "theater" of racism in antebellum America, in which people perpetuated infrastructures of inequality with "no conscious awareness" (pp. 15-16); I argue that documents, as well as people, assisted in reinforcing systemic ideologies of racial identity.

Paul Starr (1982), a professor of sociology and public affairs whose research focuses on health care reform**,** alludes to the power of documents when he writes about how medical professionals create legitimacy to ensure their occupation's success as a cohesive group within society. According to Starr, a group creates a shared body of knowledge and standards, which in turn act as "cultural authority" to outsiders (p. 12). Pierre Bourdieu (1991) notes that professionals work together to create social capital that is specific to their field. Shared resources, such as special ways of thinking, talking, and acting, allow members of a particular group to participate in and know the rules of the political game. Castel specifically points to psychiatry as a profession that actively develops specialized, or "expert," knowledge (Ingleby, 1983, p. 160). In turn, the public gives professionals, as a group and as individuals, their trust and, thus, a great deal of political capital and power. Starr (1982) distinguishes between cultural authority and social authority as two ways in which subgroups gain status within larger groups: cultural authority can reside in objects or ideas, such as religious texts and laws, while social authority controls actions through commands given by a hierarchy of social actors (e.g., doctors, nurses, patients). One type of authority is not necessarily tied to the other type. In the case of the medical community, Starr argues that cultural authority precedes social

[20] In their article that expands upon Foucault's *The Birth of the Clinic*, Berg and Bowker (1997) focus on medical records as participating in the production or performance of patients' bodies. They do not examine the production of the records during daily workplace practices, however, which is a component of my dissertation research. By studying the ecologies of records (inclusive of hospital documents rather than specifically medical records), I am looking at not only how records have shaped our perceptions but also how actors have produced, altered, saved, and destroyed records.

authority in that patients trust doctors because of the belief that doctors have the authority to read the signs of illness and to diagnose: "By shaping the patients' understanding of their own experience, physicians create the conditions under which their advice seems appropriate" (p. 14). Similarly, Ingleby (1983) posits that medical knowledge has valuable cachet as a social ordering tool because it can "regulate morality without seeming to do anything of the sort" (p. 163).

One way in which disciplinary institutions, such as governments, hospitals, and archives, maintain power over the people they oversee and perpetuate the pervading norms and social order is through control over how and what information is transmitted and retained (Jimerson, 2009, p. 232). Bourdieu (1991) theorized that various forms of speech, including written and oral forms of communication, represent and perpetuate social hierarchies by acting as a type of "symbolic power" or "symbolic violence." Other embodiments of symbolic power can be actions or institutions. The subjugated, Bourdieu argues, must be complicit with these symbols of power in order for the arbitrary, socially-constructed hierarchies to continue existing; it is *habitus*, a set of internalized dispositions, which cause agents to embody and act out, often unconsciously, behaviors that are expected from them by the society in which they live (p. 12).

In her study of the Dutch East Indies government archives, anthropologist Ann Laura Stoler (2009) argues that official colonial records are an integral part of a constant negotiation of power and the meaning of what is and is not reality. Through a historiographic examination of language, classifications, and the types of documents and their movements, she posits that the "archival form" of the Dutch colonial records reveals an anxiety by their creators about making "the rubrics of rule correspond to a changing imperial world" (p. 4). Stoler highlights the determination of institutional powers to standardize documentary information and thus strengthen their epistemological precepts despite their environment constantly shifting. In order to better understand how disciplinary institutions, and mental hospitals in particular, are able to establish and reify order through the demarcation and controlling of information, an examination of the

literature regarding how classification schemata are used in everyday recordkeeping practices is necessary.

Classification and Recordkeeping

Geoffrey Bowker and Susan Leigh Star (1999) in *Sorting Things Out* discuss how categorizations and standardizations are embedded tools developed and shared within infrastructures, and specifically within social institutions. Their primary example of an organizational system is the Nursing Intervention Classification, which is used by nurses for their recordkeeping practices and is a system understood and acknowledged by the more general medical field (cf., Berg and Bowker, 1997). Another such system particularly relevant for this paper is the Diagnostic and Statistical Manual of Mental Disorders (DSM), which was first published in 1952 by the American Psychiatric Association. Bowker and Star (1999) argue that "one can read a surprising amount of social, political, and philosophical context from a set of categories – and that in many cases the classification system in practice is all that we have to go on" (p. 55).

The specific classifications, or labels, applied to individuals are often not based solely on the observed individual, but are rather a negotiated compromise of naming that allows harmony and understanding across a potentially diverse infrastructure (e.g., the U.S. health care system). Bowker and Star ground their observations in Foucault's earlier work that found information-gathering to be a characteristic of the modern state and that, in order to produce and maintain standardized records, infrastructures require uniform gathering and encoding practices (p. 117). The resulting labels serve as "boundary objects," a term Star and James R. Griesemer (1989) introduced to describe objects that reside in multiple communities of practice and are at once flexible enough to meet local information needs and "robust enough to maintain a common identity across sites" (p.

393).[21] The precision and brevity employed in medical classification are often substitutes for representational recordkeeping work in order to accomplish efficiently the tasks at hand. For example, radiologists use parsimonious reporting to create "conservative and risk-averse reports" (Yakel, 2001b, p. 242). While classification assists in the uniformity and efficiency of communication for a specific set of situations involving specific individual and collective actors (e.g., nurses, third-party providers), for others such as health statisticians and epidemiologists, classification detrimentally "determined what was seen and what remained unseen" (Wailoo, 2011, p. 7). Classificatory systems for health care change over time to meet ongoing social needs, and, as a result, longitudinal epidemiology often has to be based on data rooted in incongruent constructs.

Bowker and Star (1999) evoke Latour in order to assert that social classifications (e.g., race, mental status), which are culturally created and defined, are reified and naturalized by being absorbed into what is considered the natural, or non-social (p. 60). As seen in the colonial race classification in apartheid South Africa, systems are often hidden under the veil of "science" (p. 202). The *Sorting Things Out* authors also point to the work of sociolinguists George Lakoff and John Taylor, who have argued that different social groups will create different classification systems and present them as the authoritative way of viewing the world. One way psychiatrists have developed their professional authority has been through the "classificatory impulse" (Dandeker, 1990, p. 147).

In the 1960s, the sociologist Thomas J. Scheff applied the newly developed idea of labeling theory to mental illness classifications. Scheff's theory proposes that psychological diagnoses are labels applied to individuals who appear to fall outside of societal norms, thus further distancing them from mainstream society. Individuals who

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[21] Education theorists Edwards and Usher (2008) have made connections between ANT and boundary objects in their considerations of a pedagogical approach that embraces learning within and between different communities of practice. They posit that non-human actants, in combination with the human work of translation and coordination efforts, can enable communication and sharing across diverse contexts.

were labeled as psychologically abnormal were often put into physically isolated institutions (e.g., public mental hospitals) controlled by "agents representing dominant social groups" (Grob, 1991, p. 285). Proponents of labeling theory, including American lunacy reform revisionist David Rothman, suggest that mental diagnoses reflected a social environment more than it did the state of an individual patient (Scull, 1983). Critics of labeling theory, such as Ingleby (1983) and Scull (1983), however, argue that the theory is overly metaphysical and does not explicitly consider the economic, political, and professional factors that shape treatment of the mentally ill, such as societal responses to poverty and the social goals of mental institutions. Regardless of the finer points of the revisionist disagreement, it is clear that the concept of mental illness is a science steeped in historical and social contexts.

Classification systems are always changing as infrastructures evolve due to cultural changes, technological growth, and time, and in turn, affect how actors and actants interact. In the late 1800s, general medicine classifications were changing from general physiological descriptions, such as "senility" and "destitution," to more specific and categorized diagnoses (Rosenberg, 1987, p. 152). Foucault (2006), in tracing the difficulty for 18th-century doctors and scientists to classify mental illnesses as they did physical ailments, notes how the names for mental illnesses in this time period were necessarily evocative of "a whole world of symbols and images" (p. 205). Metaphorical names and descriptions for mental ailments served as boundary objects so that illnesses without physical symptoms and supposed cures without measurable effects could be understandable to patients, their families, and the general public. For example, doctors used a language of signifier and signified when speaking of *black* melancholy, *vapors rising* from the abdomen, or *frayed* nerves. During that era, a divide persisted between the arguably more physical realm of medical classifications and the metaphorically oriented classifications used in mental hospitals (p. 393). The changes in diagnoses and classifications over time for mental illnesses reflect developments in the psychiatric

profession – notably, its attempts to merge with the general medical field – and in mental illness epistemology.

On the extreme end of the spectrum in defining mental illness, Thomas Szasz (1974) views mental diseases as metaphorical illnesses that reflect society's changing norms and subsequent stigmatization of groups through labels of sickness. Alluding to Wittgenstein's language games, Szasz argues that all mental illnesses are a type of game in which doctors and patients play roles involving culturally-constructed impersonation, rules, and signs (p. 10). For example, Szasz discusses hysteria as a historical mental illness that was invented by Charcot and Freud, but no longer exists in modern mental illness classification.[22] What was once labeled hysteria is now diagnosed as either a type of dissociative disorder or a somatization disorder in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (2000). In this version of the DSM, it recommends psychiatrists take a "cross-cultural perspective" especially when evaluating the former disorder because "dissociative states are a common and accepted expression of cultural activities or religious experience in many societies." Thus, the current DSM recognizes, for this particular mental condition at least, that the difference between a *state* and a *disorder* is determined by societal attitudes, which change over time and across cultures. In his examination of schizophrenia in early 20th-century admission records from the Ionia State Hospital for the Criminally Insane in Michigan, Jonathan Metzl (2009) observes that "the meanings of diagnostic categories changed even when the names of the categories remained the same" (p. 68). Metzl, the director for Vanderbilt's Center for Medicine, Health, and Society, notes that the evolving definitions of schizophrenia in the DSM are also a reflection of the changing social conditions in the U.S. In another example of a shift in psychiatric categorization, the DSM no longer listed homosexuality as a disorder after several years of activism and scientific research and the

[22] For an in-depth examination of the "diagnostic drift" (p. 523) in psychiatry and the eventual disappearance of the term "hysteria," see Micale (1993).

board of trustees for the American Psychiatric Association voting to exclude a homosexuality classification in the 1974 edition (Lamberg, 1998). A new diagnosis of "sexual orientation disturbance" was added, which later became "ego dystonic homosexuality."

Despite his dislike of how the "game" of mental illness has victimized individuals (e.g., involuntary institutionalization), Szasz (1974) acknowledges the need for such rules and metaphorical language in society (p. 161). Similarly, Bowker and Star (1999) described the need for classification for functional societies (p. 317), and JoAnne Yates (1989) views the shift from descriptive to comparative data as a necessity for the systemic management of large organizations (p. 80). According to sociologists and grounded theorists Barney Glaser and Anselm Strauss (1965), the definitional "signs" from social structures are necessary to inform interactions between actors. Classifications, stereotypes, and norms all serve as pieces of the picture of what people know or assume they know about one another, creating an "awareness context" (p. 274).

In addition to classification systems being a symbolic part of social institutions in that they represent ways of shaping beliefs and maintaining order, they are also part of the built environment (Bowker and Star, 1999, p. 39). Embodied in records, insignias (e.g., uniforms), and man-made structures and landscapes, classification systems are part of the material culture of institutions. Yates (1989) argues that internal organizational records are a necessary element of systematic management because they contribute to "corporate memory" (p. 63). After institutions are gone, such materials can continue to serve as tangible evidence of discipline, control, and an institutional perspective on controlled populations. As the historian Marc Bloch (1962) has pointed out, historical documents reveal themselves to be "the evidence of witnesses in spite of themselves" (p. 61). Echoing the anatomical metaphor developed by late-19th-century Dutch archivists to describe archival arrangement, Yates (1989) studies the "skeletal remains of the communication systems that once controlled and coordinated [companies]" in order to deduce the "muscle and flesh," e.g., the evolution of records as organizational managerial

tools (xix).[23] Pickering (1995) self-identifies as divergent from the ANT developers and other proponents of the theory in his focus on how material agency is "*temporally emergent* in practice," meaning that the future ability of materials is unknown and must be constantly revisited by human agents (p. 14). This idea is perhaps particularly relevant in thinking about the role of institutional documents once they are placed in archives and made available to individuals and groups previously unable to access them.

ARCHIVAL STUDIES

Bridging Sociology and Archives

Compared to the extensive sociological literature on the social worlds of institutions, the archival field offers fewer touchstones to serve as case studies or theoretical frameworks for how to approach the study of institutional record ecologies.[24] Nevertheless, there have been several excellent archival studies that address the ongoing values of, as well as the access restrictions to, legacy hospital records. Research with a dedicated archival perspective ensures that the focus remains on the records, and how they, as material objects, interact with other objects, work environments, and people.

Barbara Craig (1989, 1990) surveyed records from 1850 to 1950 from 57 hospitals in London and the Canadian province of Ontario, and discusses the

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[23] Cf., Section 20 (and the related Section 16) of the Dutch *Manual for the Arrangement and Description of Archives* by Muller, Feith, and Fruin (1898), which utilizes the skeleton metaphor to emphasize that archival documents, and specifically administrative proceedings, are the remaining evidence of organizational activities. Like paleontologists examining animal skeletons, archivists could view a collection as an "organic whole" (p. 69) that reflects the fluctuating, or living, quality of the organization it represents. See also Horsman, Ketelaar, and Thomassen (2003) on the origins of the metaphor and how the manual's creators eventually came to agree that the original order of documents should be maintained in an archives so that institutional functions could be reconstructed.

[24] One approach to understanding the record production work within an organization is the "documentary probe," which was developed by archivists Bruce Bruemmer and Sheldon Hochheiser (1989) as a means to appraise records in large high-technology companies. The method calls for the examination of the activities surrounding the creation of a particular product (e.g., a laser scanner) in order to identify important extant documentation and areas that need documentation.

standardization and growth of hospital records. By examining the record types and quantities over time, Craig was able to track the parallel development of administrative and medical practices. While the introduction of case files, new recording devices, and other recordkeeping technologies and practices influenced the type and amount of information recorded, the growth occurring in the administrative, legal, and medical fields were in turn affecting record production. Elizabeth Yakel (2001a, 2001b) also notes the changes in medical recordkeeping systems, specifically in radiology. Phyllis Ngin (1994) examined nurses' recordkeeping practices in three U.S. hospitals in order to understand both the social environment from which nursing records emerge and how the documents affect health care. Her main observations focus on the incongruities between what information the nurses write on official records and what information the nurses need for their everyday communication and in order to care for patients.

Finally, a few works by archivists address the privacy considerations that archivists face with medical records. Menzi Behrnd-Klodt (2008) and Anne T. Gilliland and Judith Wiener (2011) discuss the challenges of working with HIPAA while acknowledging the potential cultural and research value of legacy patient records. More recently, the Society of American Archivists and especially its Privacy and Confidential Roundtable have been taking steps to ensure that the concerns of archivists regarding HIPAA are heard at the federal level.[25]

Material Culture Preservation

Archivists should consider three facets of material culture preservation when processing institutional records that have been "abandoned" and "detached" by their creators: content, context, and artifactual properties (Taylor, 1995, p. 17). While all the facets overlap, "content" is a particularly problematic term that can point to the text,

[25] In August 2014, SAA adopted an issue brief drafted by the Committee on Advocacy and Public Policy regarding HIPAA: http://www2.archivists.org/sites/all/files/0814-1-III-A-IssueBrief-HIPAA.pdf.

sound, or images recorded on or in an object; it can also include other informational properties, such as an object's provenance, function, and physical makeup. For the purpose of this dissertation, "content" refers primarily to the former, narrower definition. Archivists can ensure that the contents of institutional records are preserved either through the physical preservation of the original materials or through processes that move the contents to other media or analogous contexts (e.g., for paper-based records, digitization and transcription; for digital objects, emulation and migration). The latter preservation strategies, while potentially ensuring greater access or long-term sustainability than the former method, nevertheless results in a loss of original content in the broader sense above, even if structural, administrative, and descriptive metadata is included.

Archivists should be aware of changes in what is and is not recorded. It is important that archivists discover what content has been intentionally thrown out by staff or systematically destroyed by an institutional administration. Trouillot (1995) posits that there are four junctures for potential silences in the production of history: the moment of source-making, creation of the archive, retrieval for the construction of narratives, and history-making retrospection. Of particular interest here are the first two possible moments of silence – the creation of records and the keeping of them. Stoler (2006) notes, "Information out of place underscores what categories matter, which ones become commonsense and then fall out of favor. Not least, *they provide road maps to anxieties that evade more articulate form*" (p. 275). With the Nelson Mandela prison records, Harris (2011) makes note of the gaps in the collection and the uncertainty of whether those files were intentionally lost in the regime change. He also notes the many changing classification schemata (along with the shifting rules, cultures, and personalities) of the apartheid-era incarceration system. Derrida (1980) implies that archives researchers can come to understand systems of institutional thought by looking at what content has been intentionally excluded from material records because institutional creators considered it

trivial information (p. 104). What institutions may justify as unimportant may also point to more expansive questions of legal and ethical accountability.

Within medical institutions, there are few inactive records that represent the work of particular professions, with nursing the focus of several studies on workplace informational practices. Bowker and Star (1999) describe nursing work as "canonically invisible" in part because of the double-pronged effort by hospital administrations and nurses to destroy the nursing records that document the latter's workplace practices (p. 268). Many of the records that nurses create, e.g., worksheets, are usually the first to be discarded after a patient is released (Ngin, 1994, p. 628). Ngin identified nurses as engaging in two distinct recordkeeping activities, one of which focused on the creation of official records that are shared with other personnel at the hospital or with an affiliated organization. Most of the formal records these nurses produced were on standardized forms for administrative recordkeeping and billing purposes, e.g., health assessments, charting, and patient classification (p. 620).[26] The other type of recordkeeping was the nurses' "systematic note-taking practices to keep track of their patients' progress and types of care needed" (p. 619). The nurses that Ngin observed felt that clinical recordkeeping, which includes the nurses' own notes and memorized information, were more valuable than administrative records for understanding patients' conditions. Ngin's observations and interviews lead her to note the incongruities between what nurses do for patients and what they record (p. 629). Part of the former work is not documented and includes what Hochschild (1983) calls "emotional labor," which is the effort to create or restrain emotions in order to produce an outward appearance that will induce specific emotions in others (p. 7). While administrators do not retain nursing records because of the assumption that these documents have no long-term research or administrative purposes, nurses often practice "partial erasure" and destroy their own informal incident-

[26] Mol (2002) talks of clinical and administrative perspectives as the two frames of reference that inform medical professionals about how to act and to interpret a situation (p. 68).

specific records to maintain professional autonomy and decision-making flexibility in their daily activities (Bowker and Star, 1999, p. 269).

As the example of nursing records demonstrates, records alone cannot reflect the entirety of institutional practices. The contextualization of existing institutional records in archives helps users understand the environments in which these documents were created and participated. The context of record creation is particularly important for interpreting classificatory systems, which are representative of specific times and places (Bowker and Star, 1999, p. 266). Mol (2002) proposes that the hospital as an "organism" depends on the flow of paperwork, meetings, studies, and so forth – even then, it is not a stable and cohesive whole (p. 84). Therefore, I contend that, beyond maintaining provenance and original order, archivists should examine the relationships between records, recordkeeping practices, the record keeper, and the recorded activities.[27]

Finally, characteristics of the recording artifacts themselves can offer insight into institutional recordkeeping activities and, more generally, the flow of information within an infrastructure. Significant technological developments for institutional organizations include copying technologies (e.g., carbon copies, Xerox), instant and inexpensive photography (e.g., Polaroid), and record-making and storage supplies (e.g., Dictaphones, microfilm, vertical filing systems, floppy discs). These technologies were intended to bolster administrative efficiency, and contributed to more records being produced (including duplicates) that were distributed both vertically within and laterally between institutions. Carbon copying can produce up to ten readable copies at a time, "allowing each department head to retain a copy" (Yates, 1989 p. 49). Records became more uniform in appearance with standardized sizes and materials (Cox, 2011, p. 136).

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[27] Cf., Terry Cook's (2006) macro-appraisal functional analysis methodology, which includes the evaluation of the "decision-making processes and deliberations, the internal organisation and structures, [and] organisational culture and communication patterns" of the institutional record creator (p. 12).

The kinds of information being recorded also changed as a result of technological innovations for the production and storage of records. For example, the replacement of case books with case files allowed documents to be filed into individual patient folders immediately after creation (Craig, 1990, p. 28). Such a switch in institutional record forms contributed to a change in both office recordkeeping practices and the archival corpus, providing a more detailed longitudinal picture of a patient's treatment and care. Other changes in recordkeeping technology include audio recording devices that allowed conversations to be transcribed. By the end of the 19th century, the typewriter and carbon paper superseded the efficacy of writing board meeting minutes by hand in pre-bound books. The development of new medical specialty departments, growing third party interests (e.g., auditors and the public), and more complex administrative and legal requirements also contributed to the increase in hospital record-production in the first half of the 20th century (Craig, 1989; 1990).

Although record forms, appearances, and numbers change over time, recordkeeping systems become ingrained components of routines for hospital staff, as with other organizational workers. Yates (1989) suggests that there is a dependent relationship between decentralized files and internal communication in an organization, with each causing the proliferation of the other. Craig (1990) notes that pre-20th-century forms of records such as board minutes and patient registers continue to serve key hospital functions. Ngin (1994) observed that nurses justified their resistance to changes in record forms, e.g., from Kardex cards to care plans, by arguing that they already had a well-established documentation practice that "dealt well with meeting information and communication needs" (p. 626). Underlying these arguments is also a sense of loss of a clinical (rather than administrative) recordkeeping system that the nursing community had complete control over – the Kardex was "strictly a nursing document" (p. 627). Problems in adjusting to changing record type, media, and format can also be seen in the transition from analog to electronic recordkeeping systems (cf., Yakel, 2001a).

Post-Institutional Archives

The choices institutions make in terms of what types of information and records to retain are mirrored in the archives, in that archivists construct meaning while they acquire, appraise, and process a collection. In the preface to the 1961 edition of *The History of Madness*, Foucault (2006) suggests that the most vital part of his work is "the space I have left to the texts *of the archives* themselves" (xxxv, italics mine). Foucault viewed archives as epistemological systems, in which what is known and not known depends on an archives' particular rules of practice (Stoler, 2006). As a result, for example, he read texts about madness from the authors' temporally-situated perspectives. But what if historical texts are not enough to tell a more complete story, especially in regard to the record subjects? Or to document the recorders, whose own personal perspectives, rather than institutional ones, were not captured on paper?

In 1987, Hans Booms, Hermina Joldersma, and Richard Klumpenhouwer revisited Booms' opening remarks at the German Archives Conference in 1971. He writes,

> The importance of archives in helping to resolve the question of sources makes it clear that the writing of history is possible only because of the existence of a documentary heritage in material form, and that the documentary heritage is the material source of a society's historical consciousness. (p. 80)

Booms was concerned about the role of the archivist in shaping the historical narratives that are accessible through archival collections. In his article regarding the study of history through archives, Francis Blouin (1999) notes that, when historical studies turn to considering underrepresented minorities and power, the existing documentation is either lacking in precision or missing entirely. He reiterates the Derridean concern that institutional archives are too removed from "the precise memory they document" (p. 105). The ability for a collection to fulfill a user's needs depends on what "memory," or whose story, the user is looking for in an archives. Blouin suggests archivists are the mediators between documents and readers, which he argues archivists

do not acknowledge enough even in this supposed post-custodial age whereby archivists view themselves as managers assisting record creators in the maintenance of the latter's records. In his discussion on the uses of archival materials from former governmental and business administrations, Hugh Taylor (1995), who served at various points in his career as a county, provincial, and federal archivist in Canada, points to the complementary tasks for the archivist to study the history of how an institution functioned and the broader socio-political impact of an institution on society. The latter activity borrows from Bearman and Hedstrom's notion of "outcomes," in which the value of a record goes beyond the record content (e.g., the activity recorded by the creator); appraisal of a record requires determining the "personal and social impact" of said activity (p. 18). Later, Taylor (2003) writes,

> The study in depth of a department's records may perhaps be approached in two ways: as a *history of the administration*, in which the works are taken apart and the entire operation analysed in relation to its parts; and as *administrative history*, in which the impact on the politics, power struggles, and the public at large is considered. This is often much more difficult and would have to include a great deal of time spent at the grass roots amongst the general correspondence. Both approaches are needed. The second is far more difficult; the first would be of greatest assistance to the archivist. Together, they might result in a number of historical revisions of, for instance, the efficacy of all sorts of major constitutional and statutory reforms. (p. 46, italics mine)

Here, Taylor only suggests that archivists look during appraisal at the "grass roots" of general correspondence in order to get a sense of the social impact, or what he calls the administrative history, of an institution.

Randall Jimerson (2011) says that archival appraisal typically reproduces power relations from institutional power brokers, such as corporate and government entities, arguing that archivists are acquiescent "co-creators" of this version of the archival record (p. 375). Harris (2011) similarly perceives much of the work performed by archivists as rooted in oppressive hegemonies, as when archivists arrange and describe collections using technological and intellectual systems that are intended to be absolute in their

control. Therefore, Harris advocates, that for many post-colonial collections such as the Mandela prison records, the archivists' job as an activist to tease out the institutional layers and fill in gaps in the record has just begun (pp. 356-360). According to Harris, the archivist is responsible for bringing attention to hierarchies of power and to the marginalized. The records of past institutions and governmental administrations have potential uses that go beyond evidentiary value. They can also serve as a participatory tool for digital archives users to interact with (and react to) the records and with one another in a community environment.

Archives-Building for Minority Communities

Between Postmodernism and Traditional Archivy

The LPH project differs from most post-custodial community archives and user-oriented projects because of the ongoing institutional presences such as the hospital, the state attorney general office, and the state archives. Information from LPH records are governed by laws and policies that require specific chains of custody in which only a limited number of state agencies can control the physical documents and determine who is allowed access to specific kinds of information. Therefore, the LPH archives project is uniquely situated on the cusp of two modes of archivy; the project members are navigating between the established, albeit constantly unstable, relationships and actions of state and federal institutions (e.g., archives, hospitals, legislatures, laws, and regulations) and an untested arena of digital innovation to increase access to mental health records. While my initial impulse is to doggedly pursue the latter, it is tempered by the recognition that success for the LPH project lies somewhere between the two social worlds. As we, the LPH project members, seek to increase community participation in the archives-creation process and to broaden access to the collection, we also want to uphold the laws and policies that govern access to personal health information in the physical records. In the following section, I have looked at the literature from archival studies to

trace the rise of postmodern archives and to gain an understanding of how the LPH project fits into the movement and how it does not.

The postmodern movement in archival practice calls for participatory actions by record subjects and/or local communities that may range from contribution of materials to collections to control over the daily operations and mission of the archives. When institutional records are under the custodianship of a community-run archives, it is the responsibility of the community members to decide if and how the materials are accessed and used. In this section, I posit that the postmodern and post-custodial model of archivy has characteristics of activism, community participation, and redress that are important when managing sensitive and potentially controversial institutional records. Community archives can cultivate uses for archival post-institutional materials that go beyond the more passive custodianship of conventional Western archival facilities. However, depending on the level of commitment, financial support, and archival knowledge of the record community in question, it may be necessary to have trusted third parties such as state archives be the primary keepers or co-custodians of institutional records that contain information restricted by privacy laws. It may not be feasible for community archives to master the everyday maintenance of institutional records, especially documents from mental health facilities.

The postmodern and post-custodial movement in archival studies began in the 1970s as a response to the positivist view of the archivist as a "selfless devotee of truth," and an impartial preserver of evidence (Jenkinson, 1944, p. 16). Gerald Ham (1975) saw the need for the "active archivist" who would redress imbalances in the archival record by taking a proactive stance in documenting society (p. 6), or, as Harris (2011) and others later push further, to "embrace the role of memory activist" (p. 346). Helen Samuels, Larry Hackman, and Joan Warnow-Blewett, among others, developed the archival model of documentation strategy as a means to "document institutions as adequately as possible" (p. 8), given that archivists cannot predict future research needs. Jimerson (2011) suggests that documentation strategy should include the collecting of records from

actors who are not well-represented in archival collections, if necessary; provenance can thus be expanded to include "collective social entities" (pp. 373-374). Activist archivists engage with minority groups in order to develop additional metadata for records and to create new context via supplementary records. Endeavors to build communities through digital venues appear to have moved in tandem with increasing efforts to digitize archival materials and create digital archives and libraries.

If archivists view archival materials as having multiple points of creation and meaning, and "always in the process of being made" (Duff and Harris, 2002, p. 265), archival activities beyond studying issues of power become possible. This postmodern approach to archives aims for activism, empowerment of minority groups, and community engagement (McKemmish, 2002). Documents can take on new meaning when they are no longer used by the institution from which they emerged and were used. According to Jimerson (2009), historians in the last 40 years have been looking at issues of power, disenfranchised minorities, race, and gender, and they have noticed that these groups are difficult to study through existing documentation because they either did not create documents or such documents were not preserved in public archives (p. 216).

Much of the literature on the relationship among archives, institutional records, and communities comes from writings on postcolonial archival creation and the records continuum/Australian model of record description (Hamilton, 2002; Harris, 2007; Stoler, 2009; Riedlmayer and Naron, 2009). Since the rise of decolonization after World War II, communities composed of ethnic, racial, and cultural minority groups who have historically not been able to contribute records or have been misrepresented in the documentation kept by official state archives have had the opportunity to collect and present materials that they believe reflect their heritage (Punzalan, 2009). This process includes the repurposing and reinterpretation of official government documents of previous regimes. The postcolonial archives often emerged from state archives that were once controlled those previously in power, and are now being run by groups native to that region.

Thirty years ago, Hugh Taylor (1982) wrote about how community interest in heritage preservation has altered how institutional archives have approached collection development and appraisal: "Contact and experience with alternative institutions practicing active personal involvement already modified the public bureaucracies, of which archives form a part" (p. 124). Furthermore, Taylor argues that administrative records can certainly be part of a community's heritage, and studying how records were managed can reveal a great deal about the relationship between an institution and the community it serves:

> The connection of records management with heritage may seem rather remote. Yet, if the 'collective memory' is to be systematically updated to contain not only administrative decisions but also the response of the community to its administrators (and producers in the private sector), operational files must be retained that are appropriate to record linkage and other techniques of quantitative history. (p. 126)

Taylor points to the continuing use of institutional records as part of a "collective memory" that goes beyond institutional recordkeeping or administrative culture. Eric Ketelaar (2005), borrowing the political science term of "community of memory" for archival theory, suggests that "to be a community, a family, a religious community, a profession involves an embeddedness in its past and, consequently, in the memory texts through which that past is mediated" (p. 7). Therefore, records that may serve as the material objects, or the "objectivized culture," to reinforce corporate memory for a professional community can be "cultivated" again for a different kind of cultural memory for other types of communities (Assmann and Czaplicka, 1995, p. 131).

Within the community archives framework, archivists and archives can be part of the cultural brokering process; they mediate the interactions between records, which are mediators themselves, and the minority communities portrayed in documents. In summarizing the essays in Jeannette Bastian and Alexander's *Community Archives*, Richard Cox (2009) comments on the powerful societal role of archival records and repositories, especially in negotiating relationships between a group and the larger society

within which it resides. He writes, archival records "perform complicated roles of commemoration, celebration and communication that establish or strengthen communities," and furthermore, they "serve interesting and complicated roles related to the power of particular groups in any society or culture within that society" (p. 254). Ernest (2004), who is a professor of African American literature, promotes "liberation historiography," a form of writing about history by minority communities (e.g., African Americans) who were misrepresented or excluded from the official records that once served as the dominant form of historical evidence about those communities. Echoing Benedict Anderson's (1991) imagined communities, Ernest calls for groups who have been defined by and share an identity under systemic inequalities "to work from an understanding of the historical condition of oppression to a vision of [self-determined] historical agency" (p. 18). Such agency can be achieved, he argues, through the construction of historical writing that acknowledges both the "fragments of history" found in archival institutional records and the previously unwritten experiences of their communities (p. 5).

Bastian (2003) argues for the importance of retaining administrative records as part of community archives. Such written history "becomes a primary link in the ability to define the community narrative and forge community identity" (p. 47). The records act as "frameworks for interpretation" that can support or contradict individuals' memories. The reliability of both oral and written records is mutable and dependent on the context of access – who is looking at the records, and why she is looking at them. Bastian notes that institutional records, specifically government records, have an uncertain role in postcolonial societies because the documents' meaning depends upon the interpreter. For Bastian, the plurality of voices found in archival records is necessary for a community to "authenticate, evaluate, sift, and distill a memory on which it can rely" (p. 47). Borrowing from Terry Cook's notion of a conceptual provenance and Ham's call for archival activism to better document society, Bastian suggests an archival framework in which community participation in archival creation would include community members'

contextualizing existing former institutional records and creating new records. This process would facilitate a "sense of co-ownership of the records" (p. 82), both institutional and community-provided.

Part of the postmodern approach in archives usually includes a "radical user orientation" (Huvila, 2008, p. 32) that strives for greater user contributions to the archives, whether as metadata commentary on existing items, additional archival materials, or creative reuse of the collection. The approach makes the availability of archival materials the highest priority, rather than secondary to the organizational and preservation purposes of archives. Both user-centered archives and studies about participatory use in archives are relatively new areas of interest, when compared to the longer histories of user-centered engagement in the library and museum fields. While not explicitly calling for participatory archives, Helen Samuels (1986) influenced this approach with her refined version of documentation strategy in "Who Controls the Past."

One benefit of the user-oriented strategy is that the users themselves perpetuate the digital archives' development. The archival users determine the best ways to organize materials. They also select the digital objects' significant properties, or characteristics, that are necessary to preserve in order to ensure the items remain meaningful, accessible, and usable over time. While typical Western archives may wait for collections to come to them, as when institutions no longer need certain records and pass custodianship to an archives, the activist archivist goes into communities to seek individuals with "material sources" that can be contributed to an archival collection, whether documents, artifacts, or recorded narratives. Community contributors offer perspectives on people, places, and past events that are not seen in institutional records, and their engagement with archivists and archives can arguably give them a sense of ownership of the collection materials (both institutional and their own contributions) and of the archives itself that might not otherwise occur. A relevant project of note is the "Archives of Mental Health Recovery Stories," which is an online collaborative project of the Wellcome Library, University College London doctoral student Anna Sexton, and individuals who have experienced

mental health difficulties. Through oral narratives, artwork, and other forms of expression, the participating former patients have been able to contribute personal narratives to the Wellcome Library's mental health digital archives.[28] The digital medium has been a major tool for community archives, as it can reach geographically dispersed populations and generally can offer a wider variety of ways to participate in the creation and use of archival collections than can conventional archival environments.

Digital Archives and Archival Principles

A major ongoing component for the LPH archives is a digital archives that ideally will permit different user groups varying levels of access to record information dependent on the record information's restriction status and, at a more granular level, a specific user's relationship to the record subject. In this section, I suggest that a digital archives for the LPH archival records can serve as an intermediary step or way station between traditional Western archivy and a postmodern model of community participation. The LPH digital archives can be successful only if the team negotiates with the presiding institutional actors on how to integrate elements of archives-building for under documented groups into the digital archives structure. The primary issue at hand in developing a digital medium for the LPH collection is whether the digital archives will uphold foundational archival principles and, more importantly, if it matters. Here, I briefly outline the foundational ideas underlying archival practice, then I present some newer archival models that are particularly amenable to digital technologies and reinvent why archivists should strive for archival values.

In 1961, T.R. Schellenberg argued that the maintenance of provenance is always necessary to maintain the "integrity of archives" (p. 23). According to Schellenberg, who is echoing Guizot in 1839, records are evidence of action. In order to uphold the

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[28] http://mentalhealthrecovery.omeka.net/

evidential character of records when they are later used in an archives, archivists should adhere to the principle of provenance or *respect des fonds*. Provenance holds that archival work should maintain the structure and function of an institution through documents. As a result, every record has a place within a body such as an institution, and within an activity. Each record has greater meaning when it is part of a whole than when it is alone. Schellenberg argued that, in keeping archival collections in original order, they maintain their Jenkinsonian evidential value to archival researchers.

The maintenance of provenance is an important aspect of ensuring the authenticity of documents. For Terry Eastwood (1993), "authenticity is the quality of archival documents to bear reliable testimony to the actions, procedures and processes which brought them into being" (p. 243). Eastwood, in support of the Jenkinson model of archival institutions, limits the social role of the archives, specifying that the purpose of the archivist is "to preserve the integrity of archival documents as faithful and trustworthy evidence of the actions from which they originated" (p. 237). He says that the primary purpose of an archives is to provide researchers with evidence; this is in contrast to researchers whom he characterizes with rather overt disdain as seeking "information" about seemingly random topics (p. 239). Eastwood asserts that impartiality is an inherent archival quality, an assertion with which the postmodern archival community fundamentally disagrees. In a postmodern archival environment, the determination of what goes into an archives and how it is organized starts with the institutional creator but continues with the decision-making of the archivist and policies of her archives. Authenticity – the ability for a document to serve as a witness to past actions – is still desired but not necessarily fulfilled by the institutional records alone.

Frank Upward's (1997) notion of "pluralizing memory" in electronic environments is particularly evident in human rights digital archives efforts, both in relatively recent postcolonial nations and in the U.S. Upward's records continuum model "emphasizes overlapping characteristics of recordkeeping, evidence, transaction, and the identity of the creator" (Pearce-Moses, 2005). Thus, unlike Schellenberg's concept of

primary and secondary use, there are no distinct stages of a document's life cycle. The human rights projects reflect a mixture of historical government records and recent testimonials. Echoing the challenges faced by any archival project that has to manage sensitive and potentially emotionally, financially, or politically damaging materials, postcolonial and post-conflict archives must negotiate what information should be made accessible, to whom, and if and how they should present archival materials in ways that encourage individuals to engage critically with the objects and with other viewers . Projects focusing on regions of recent postcolonial strife include the Documentation Center of Cambodia and the Human Rights Documentation Initiative.[29] A U.S. civil rights oral narratives project of note is the joint effort between the Library of Congress and the Smithsonian called the Civil Rights History Project.[30] At the 75th Annual Meeting of the Society of American Archivists in August 2011, Laura Caldwell Anderson compared the civil rights oral documentation being conducted in the U.S. at her institution, the Birmingham Civil Rights Institute, and in South Africa at the District Six Museum. All of these projects reflect a post-custodial model of archives that encourage contributions and even shared authority from the records' subjects and participants of the documented era.

New media and communicative technologies have greatly facilitated community participation, and even empowerment of cultural identity, in archives. Through online digital archives, archivists and cultural communities have the potential to interact with collections and each other while shaping histories. In discussing the power of archivists to determine how the past is interpreted through records, their arrangement, and their contextualization, Margaret Hedstrom (2002) introduces the concept of "archival interfaces." She suggests that these interfaces are "where power is negotiated and

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[29] Documentation Center of Cambodia: http://www.dccam.org; Human Rights Documentation Initiative: http://www.lib.utexas.edu/hrdi

[30] http://www.loc.gov/folklife/civilrights/

exercised" (p. 22). Of particular interest to Hedstrom are online archives as the most recent instantiation of an archival interface in which physical proximity to the original records (if they are paper-based rather than electronic) is no longer required for access. She argues that the complexities of appraisal, description, and user interaction with materials increase with the online medium. Elizabeth Yakel (2011) posits that the collaborative aspects of the Web have helped shift archival practices from taking place entirely in physical spaces and increasingly occurring in online social spaces. Authority also moves out of the hands of the curatorial archivist, and into a distributed one that creates a collaborative environment.[31] Yakel argues that authority over archival collections can thus become non-rivalrous among researchers, archivists, and communities at large. Kim Christen (2011) similarly posits that recent technological changes allow Native people and "experts" to have equal voice in the administration, organization (e.g., cross-cultural taxonomy), description, and access settings for digital archives of indigenous materials, as is the case for the Plateau Peoples' Web Portal.[32]

Isto Huvila (2008) highlights the possibility of having "a multitude of entry points to the information" in digital archives, especially since the designated communities for archival participation are not defined until after the archives is made visible online (p. 18).[33] In the case of digital indigenous archives (and potentially also digital hospital archives), users' interactions with the archives' content depends upon each individual's preexisting relationship with the community portrayed in the records. Here it is useful to

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31 Cf., Upward (1997) on the need for distributed custody in order to maintain provenance in an online setting.

32 http://plateauportal.wsulibs.wsu.edu/html/ppp/index.php

33 Huvila (2008) distinguishes between a "participatory archives" and a "participatory archiving model" [as described by Yakel, Shaw, and Reynolds (2007) and Shilton and Srinivasan (2008)]. The latter is arguably a more conservative approach to users' participation in archives, as it calls for "participatory information seeking rather than participatory management" (p. 26) of the archives. Therefore, while users can add information about resources, the archivists ultimately control archival content and form.

think of symbolic interactionism and its roots in pragmatism (Mead, 1934; Goffman, 1961; Blumer, 1969), Strauss et al.'s (1963) negotiated order, and Glaser and Strauss' (1965) interactions. The users' relationships with the materials depend upon their "knowledge sets" (Christen, 2011, p. 207). External restrictions (e.g., cultural, legal) that determine her status will preemptively decide what a particular user can access. The user's familiarity with and comfort engaging different culturally-constructed information systems will also determine how she will engage multiple metadata schemata that are presented in parallel.

The availability of archival collections through digital technologies, just as it for records in brick-and-mortar archives but with a far broader potential audience, comes with the possibility of records being repurposed and disassociated from their collection context. Digitized institutional records can be decontextualized easily in their reuse, especially when viewed by people with limited knowledge about the materials. Berg and Bowker (1997) note that physician's progress notes are uninterpretable without the context of the other entries. They say that "medical records always describe past action in the context of a set of organizational arrangements" (p. 523). There is a comparable risk in the digital environment if users search for key terms or phrases and attempt to interpret them without having familiarity with the context of their usage. The creation of a collection of digitized images from different institutions and the construction of a thematic narrative that entirely dislocates the records from their fonds is a step even further away from the original archival order. Without a holistic picture of institutional activities, viewers of archival hospital records in particular are able to see only text or images that may be sensational or disturbing out of temporal, political, and social context.

In a *Slate* article examining the use of historical medical images, Rebecca Onion (2014) posits a dichotomy between what she calls a "well-curated print presentation" of contextualized images from the Wellcome Library and the use of the same or similar images on "Pinterest, Tumblr, or Twitter." The latter images, Onion argues, are often

grouped together in a way that is "misused and misunderstood."[34] She generalizes the Web as a medium for flippant projects; she does suggest, however, that the Web has the potential to be as "serious" a medium as the printed page. As evidenced from the quotations she uses from her interview with Michael Sappol, a historian at the National Library of Medicine, she infers that there should be no restrictions on viewing historical medical records on the Web. Indeed, for some living former patients who may have experienced forced hospitalization, the ability to give consent to the sharing of their records with the public or creating their own lived narratives can be empowering. Rather, Onion's article raises questions about *how* the images should be presented in ways that are educational and/or meaningful to the viewers.

While Onion (2014) does not examine the ethics of medical subject images being used for publicly available creative or academic works in any medium per se, she implies that there are Web-based presentation methods that encourage "contemplation" by its viewers. In fact, Onion and her editors experiment in the article with the tactic of having mostly pre-20th-century medical illustrations hidden beneath "click to reveal" overlays. She posits that while such overlays may make the images more sensationalized, they also force the viewer to pay greater attention to each image and the person portrayed in it. I argue that the use of a digital veil can be a social cue for a viewer to feel discomfort about a potentially shocking image. Although the article's image overlays and the illustrations are effective at making Onion's point, they are also without much context and ironically demonstrate the potential superficiality of dislocated digital images.

While the digital medium provides a means to separate archival objects from their collections, it also allows the possibility of collections and single objects to be united digitally with others. Digital archives have the potential to permit multiple repositories,

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[34] The most prominent example of de-contextualization that Onion offers is not from the Web but from a videogame. She describes the use of Paddy Hartley's illustrations of World War I soldiers with severe facial injuries by Irrational Games to develop the mutant monsters for the first person shooter game, *Bioshock*.

individuals, and communities to contribute materials to a central site and one search.[35] Tom Thurston called distributed online networks "aortals," which are associative portals (Yakel, 2011, p. 274). Hedstrom (2002) notes cautiously that online archival access allows the distinction between "archival space" and other sources in the online environment to blur (p. 42). Her apprehension raises the question of what archival interfaces should look like in the digital realm, and if and why being distinctively "archival" is important online. Peter Horsman (1999) observed that the archival inventories of the 19th-century do not adequately reflect the complexity of organizational records management in the 20th-century and beyond, especially the messy processes of record administrators changing from old filing systems to new ones. He writes, "Dynamic multi-dimensionality is hard to capture in a bi-dimensional inventory" (p. 46). Therefore, he advocates for the "preservation of existing structures in an open fonds" (p. 51), which is achievable in digital settings.

The digital environment permits the possibility of having multiple organizational schemata to exist simultaneously and be available for others to use, if preserved. Horsman (1999) argues that there are many ways to define a fonds structure; while a record structure system can illustrate the functions of an organization, it can also show the arrangement of institutional records as ordered by registry clerks and secretaries or the relationship between the records and their contexts, contents, or form.[36] Digital files enable the possibility of rearrangement and selection of files, series, or entire collections by users to suit their specific needs after the initial archival processing. The electronic medium also allows the potential inclusion of user-generated objects that did not originate from an institution or organization's collection but can be connected to one or

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[35] The Digital Library of Georgia's Civil Rights Digital Library is an example of an access point for multiple collections: http://crdl.usg.edu/

[36] *The Valley of the Shadow* is an example of a digital archives that presents Civil War-era records according to the "different aspects of daily life" that the records portray: http://valley.lib.virginia.edu/

more records from the latter through a different relational element. Such elements might be community and institutional perspectives regarding a specific event or the works created by an individual as a member of an organization and independently. While a digital archives can and should maintain provenance in order to ensure the records' evidential value, the objects can go on to serve a multitude of other non-institutional purposes.

The Problem of Record Subjects and Agency

In my archival studies literature review, I have presented the archival scholarship that situate the LPH project and my dissertation work. I found that there is a substantive body of archival literature - from the considerations of how to preserve post-institutional records to the development of a digital archives – that underlie the methodological approach for the project and my research. However, one research area remains notably absent: the agency of the subject of records. Specifically, the post-custodial archival model and the literature from postmodern-leaning archivists, which heavily focus on the decisions and actions of minority groups and formerly subjugated communities, do not adequately address the problem of record subjects' participation in and empowerment through archival actions when the subjects have no agency. When I speak of agency here, it is different from the agency of ANT, in which people, objects, and ideas mediate relationships. Rather, I refer to the ability of an individual to make independent choices. In this section, I first present what record subject agency can look like in real world archival contexts. Then I discuss the particular agency questions associated with mental health patients and their records, especially the necessary inclusion of third-party participants and accompanying complications.

Vulnerable recorded populations that include the mentally disabled and the mentally ill often do not have a voice in deciding if they wanted to be documented when they are under institutional control. Depending on the situation, subjects of institutional records can gain varying degrees of control over information about themselves over the

course of the records' lifespans. Two examples of record subjects who achieved power over if and how their records are used in archival settings are from the Mississippi State Sovereignty Commission and the Culion community in the Philippines. I have selected these two cases because they illustrate the range of record subjects' participation in archival projects. Records from the Mississippi State Sovereignty Commission, the state's agency appointed to conduct activities in opposition to the civil rights movement from 1956 to 1973, were given to the Mississippi Department of Archives and History (n.d.) in 1977 as a closed collection. When the archives were ordered by the court to make the records publicly available in the 1990s as a digitized collection, a review was first conducted to ensure that the individuals named in the records could be provided privacy if such protection was wanted. The archives performed the privacy review by first locating through newspaper ads non-governmental individuals named in the files who were deemed "victims." Before the documents were processed and digitized, each individual who responded was able to select the level of public access to his records that he would allow. The digital archives platform enabled the archives to redact any information per the record subjects' requests while still making a substantial amount of the collection available to the public.[37] While the Commission's records ultimately came under the custodianship of a third-party institution, i.e., the state archives, the living subjects of a controversial and sensitive collection were able to determine if they wanted to become publicly identifiable by those records.

In my other example, the island of Culion was for a hundred years under the oversight of a health department, whether as part of the American territories, the Commonwealth of the Philippines, or finally the Republic of the Philippines, because it had been designated a leper colony. When former leprosy patients and descendants of patients of the Culion community took custody of the colonial medical records for their

[37] http://mdah.state.ms.us/arrec/digital_archives/sovcom/index.php

own archives, they were able to integrate the materials into their own community identity (Punzalan, 2009, p. 199). Foucault, in positing that power is a strategy rather than something to be possessed, argues that networks of relationships and tactics bring about power (Dandeker, 1990, p 23). The subjects of both the Sovereignty Commission and the Culion records were able to gain a sense of empowerment through conscious decisions to work with archivists and by taking control of their own records. While these two cases highlight the different degrees to which the recorded subject can participate in archives creation, the question remains if it possible to have a post-custodial type of archives when the recorded subjects are either deceased or mentally incapable of making decisions about their own records.

In general, patients undergoing medical treatment can now view and obtain copies of their own records if they wish. In presenting her idea of the "logic of care," Mol (2008) describes environments in which diabetics make choices with their doctors in a collaborative, iterative process. She acknowledges, however, that this "active" patient scenario is not always possible, e.g., patients with dementia. When patients are not able to partake in self-care, the demands on medical professionals, family, and friends change (p. 90). The burden includes maintaining the privacy of the patients' health care record information. Therefore, while patients with limited or no capacity for agency remain part of the ecology of their records – they are, after all, the subject matter – they are not active participants in who accesses their active or inactive medical information. Individuals who might not have the faculty to act independently, such as young children, the mentally disabled, and the mentally ill, have personal representatives who can access their PHI to varying degrees dependent on the relationship of the representative to the patient (Dept. of Health and Human Services, 2006). The exception to patients' or personal representatives' access to mental health records are psychotherapy notes, which are considered to be the health care provider's personal notes and are not legally required to be retained; psychotherapy notes are kept separate from medical and billing records in order to qualify as the possession of the individual medical practitioner (APA Practice

Organization, 2014).[38] The lack of deliberate interaction with medical records by patients without agency continues into the archival stage of the record lifecycle, but the social ecology in which the archival records reside is complicated by the presence of additional stakeholders and their differing opinions regarding the utility of maintaining patient privacy after the subject is deceased.

Similar to how patients without agency are not capable of mindfully interacting with their active medical records, it is not always possible for former patients to be responsible for determining who can access their medical information. This lack of decision-making power can be due to mental inability or death. The ownership of institutional records in post-institutional environments becomes increasingly complex when the record subjects do not have the capacity to choose the outcome of their records and the information they contain. Multiple parties and individuals can come in conflict with one another over decisions regarding the possession and use of records. Greene (2003) points out the multiple stakeholders of historical records when he asks,

> Who has the right to own this documentation: the individuals and families, or repositories within the community (often underfunded or largely invisible to outsiders), or traditional repositories (most of which are located in historical societies and universities that are seen as 'other' by these communities)? (p. 98)

With historical institutional records, who should speak for the privacy rights of the dead? The responsibility may lie with the direct descendants (if any), community leaders, the government, or archivists. In regard to privacy, some record stakeholders may want to make the documents open to the public, while others may not, especially if the records contain potentially embarrassing or incriminating evidence about the record subject or the

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[38] OpenNotes is a grant-funded project sponsored by the Robert Wood Johnson Foundation to increase and improve upon patients' involvement in their own health care by having doctors share their personal notes with patients. The trial run was successful in that, by having doctors share more of their thought processes underlying their medical decisions with their clients, patients expressed feeling like they had greater control over and understanding of their health care treatment plan (Wielawski, 2014).

institutions. Is it necessary to have third-party archival custodians manage post-institutional mental health records, not only for legal reasons, but also for adequate management of sensitive and potentially harmful information? Greene, who would argue eventually against community involvement in archival activities, poses the question of control over archival records in terms of ownership, with the documents and the information they contain categorized as property.

At present, neither former mental health patients nor their families have a voice in institutional archival processes, other than the approval or denying of PHI access requests. In the case of LPH, the records are created by and are the property of the hospital. Thus, select genres of records will come under the custodianship of the state archives. Mental health records, however, arguably belong to a number of other non-organizational actors when viewed from a social ecology perspective in which the records are part of a larger network of actors and actants. Stakeholders include the record subjects, their descendants, and the individual creators of those records, such as the nurses, attendants, and doctors. As I discussed earlier in the first part of my literature review, state and federal legislatures have enacted laws and record-holding institutions have adopted information access guidelines to protect medical record subjects, but the social responsibility of negotiating the privacy rights of patients and the potential value of records as a resource for social history, medical research, and genealogy can – and I argue, *should* – be more broadly construed in order to begin addressing the power inequities that are a part of the records' provenance.

Chapter 3: Methodology

THEORETICAL FRAMEWORK: SOCIAL CONSTRUCTIONISM

I approach my dissertation research using an ontological framework of social constructionism, which posits that an individual builds her reality about herself and her environment through discourses. In order to make meaning from the multiple perspectives that she encounters, the person goes through iterative and interpretive processes that can be unconscious or conscious. Her worldview is the result of a constant construction of internalized perceptions and ideas. I will be using this ontological assumption as the foundation for my own inquiry process, which is further discussed in the methodology section below, and as the theory that explains how actors within a specific ecology come to understand their reality.

Anthony Giddens' (1984) structuration theory proposes that agents are always actively reproducing social systems, both intentionally and unintentionally. His theory, rooted in the larger theory of constructionism, is particularly useful for examining the role of records in assisting with the enactments necessary to create seemingly permanent institutional practices. While Giddens suggests that objects can be agents – "To be human is to be an agent – *although not all agents are human* – and to be an agent is to have power" (Jary and Jary, 1991, p. 123, italics mine) – he nonetheless emphasizes that humans have control over objects. Actor-Network Theory (ANT) proponents and earlier constructionism forebears argue that objects have greater agency, in the sense of effect over ontological situations, than Giddens suggests.

George Herbert Mead, who was part of the American pragmatist tradition and developed American constructionism as part of the Chicago School in the 1920s and 1930s, argued that an individual's knowledge and beliefs are situated relative to her own physical world. Materiality, according to Mead (1964), is integral in the shaping of people's worldviews: "Physical things are perceptual things" (p. 314). In other words, there is a "sociality of things" (Clarke, 2005, p. 7; cf., Dant, 2005). ANT researchers (Latour and Woolgar, 1986; Mol, 2002, 2008; Latour, 2005) more explicitly state that

humans are not the only ones who shape reality. Ideas, objects, and actions can be active participants in creating a milieu of understanding and belief. Actors and actants are working together constantly to maintain a stable perception of the world. And, when enacted cultural practices and ideas become longstanding, actors can believe their cognitive positioning in the world to be self-evident. In other words, shared viewpoints can become cultural beliefs or norms. Foucault (2006) posited that there are no universal or natural truths. Rather, what may be perceived as reality is achieved through group maintenance of systems of knowledge and power.[39]

All actors, including patients in mental health facilities and other "implicated actors" who are primarily discursively represented (Clarke, 2005, p. 46), perform explicit and implicit actions that work together to give institutions the appearance of inherent stability (Goffman, 1961; Strauss et al., 1997). In their study of Chicago psychiatric wards, Strauss et al. (1963) observed how the interactions in these institutions among individuals, and between individuals and their surroundings and non-human objects, constantly negotiated order, discipline, and hierarchies: "Negotiation has many dimensions. It can be overt or covert, periodic or extraordinary, standardized or novel, general or specific in scope. But the dimension that we wish most to emphasize is the *temporal one*" (p. 311, italics mine). When conducting research through a constructionist lens, researchers should cast a critical eye toward the appearance of organizational equilibrium, and question how and why particular institutional ecologies form at a given time. What knowledge do individuals have at a given moment, and how do records play a part in providing information?

To address the role of records in how knowledge is generated, shared, and changed, I use an epistemological framework of interpretivism, which calls for the examination of multiple viewpoints and actants, including myself as an academic

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[39] Cf., Elliott, Wolber, and Ferriss (1997) on "ethics" determined by authorities.

researcher and as a participant in the Larch Point Hospital archival project. As an epistemological method, it also encourages an iterative process for examining interactions. While interpretivism does not need to be based on postmodernism per se, I am basing my research on the perspective that all knowledge is culturally and socially produced, and that there are no universal meanings. Information system scholars Heinz Klein and Michael Myers (1999) created a set of principles for interpretive field research based on hermeneutics, the study of interpretive processes:

- Hermeneutic circles: The meaning of things is a social phenomenon, and will differ from individual to individual, as people bring their experiences and perspectives to how they see the world. Everything we perceive can be viewed as a "text" to be read, or interpreted, from our individual standpoints, which are also shared and social. In interpretivism, the researcher's acknowledgment of heterogeneous viewpoints is a necessary step to come to a holistic understanding of a thing's meaning. The hermeneutic circle engages this epistemology by suggesting that a researcher can explain her own particular subjectivity only through other subjects' positions, which in turn must be understood in the context of other subjects' positions, and so on. The pessimistic view of the hermeneutic circle is that it renders understanding into a perpetual cycle of infinite regress if it is not broken (Bardzell, 2009). The goal for the researcher is to understand the positioning of her perspective within the larger social discourse about the object of interest. According to Charles Taylor (1971), "[W]e are trying to establish a reading for the whole text, and for this we appeal to readings of its partial expressions"; in other words, "partial expressions" can be made sense of only if they are put in relation to other expressions and "ultimately the whole" (p. 6). Although Taylor suggests the possibility of relying on empiricism instead of interpretation, he recognizes that empirical researchers would nonetheless be unable to escape the hermeneutic circle, even if unaware – they remain observers

from a particular viewpoint and their data are not impartial. Therefore, it is more productive for researchers to recognize the hermeneutic circles that they work within. Klein and Myers (1999) argue that such circles are the key epistemological iterations necessary for understanding communications because multiple performances of these process cycles can lead to "web[s] of interpretations" (p. 73). Furthermore, "recognizing the hermeneutic circle(s) in which you operate de-naturalizes your work and renders it visible to reflection and critique" (Bardzell, 2009).

- Contextualized understanding: Wilhelm Dilthey, a 19th-century developer of the social sciences, presents in the *Introduction to the Human Sciences* (1883) the concept of *verstehen*, or understanding of context. A century later, feminist theorist and technology scholar Donna Haraway (1988) advocates for scientific work that is based in what she deems "feminist objectivities," which strives for contextualized and partial knowledge through a "commitment to mobile positioning and to passionate detachment" (p. 585). She argues that researchers who present positivist knowledge claims are irresponsible because they do not locate them in a specific perspective or acknowledge the differing viewpoints of others, especially those who are subjugated and silenced. While researchers can never know what it is like to be someone or something else, they can seek out how others view and understand the world in the past, present, or over time. Like Taylor (1971)'s "partial expressions," Haraway's "partial views" can be joined together "into a collective subject position" (p. 590).
- Interaction between researchers and studied actants: The research should recognize the interplay between the researcher and participants. For my research, this interaction includes my ongoing relationship with participants as both a doctoral researcher and as the LPH project archivist. It also encompasses my relationship with the material objects from which I am collecting data. Besides the objects being the focus of my research, I acknowledge my participation in

attempting to construct values for the old hospital records that are different from the ones intended by the record creators. I have organized the documents into an archival collection and continue to promote it as a historical collection of cultural heritage artifacts that is worthy of preservation and future access.

- Abstraction and generalization: Rather than a positivist testing of theory, an interpretivist approach is to use theory (e.g., ANT) as a lens to view data in order to generate further theories, insights, and implications. By relating theory to her data, the researcher can analyze and explain her data within a broader context. Influenced by Goffman, Anthony Giddens (1984) believed that it was necessary to study "day-to-day life" in order to understand the "reproduction of institutionalized practices" (p. 282).[40]
- Dialogical reasoning: Interpretivism requires reflexive and documented practices in which the researcher recognizes and compares different frames of reference, including her own perceptions and those seen in the data in the form of human and non-human perspectives and representations. For example, I have had to examine my own presumptions about how records mediate the relationship between medical staff and patients. Based on my reading, I presumed all medical patients were under a Foucauldian "gaze" in large part because of records: "The science of mental illness, such as it was to develop in the asylums, was only ever of the order of observation and classification. It was never to be a dialogue" (Foucault, 2006, p. 486). The accumulation of information about patients through the act of writing and recordkeeping allowed clinicians to unearth supposed truths about patients' bodies while also "othering" them in the process (Berg and

[40] While Giddens emphasizes the impact of time and space on individual perceptions and subsequently societal development, he does not discuss the significance of place as another "socially constructed and contested" factor (Urry, 1991, p. 172; cf., Freeman and Audia, 2006).

Bowker, 1997; Clarke, 2005; Anderson and Dietrich, 2012). Through my research using the LPH records and my interviews, however, I have been able to compare this Foucauldian perspective with other, newly gained viewpoints. As a result, I have found that the relationships between records, patients, and medical professionals are far more complicated than a unidirectional "gaze," and perhaps could instead be characterized as a "surveillance assemblage" (Haggerty and Ericson, 2000), which is an "emergent and unstable" (p. 609) aggregation of heterogeneous monitoring. Such an assemblage is pervasive and affects every actor in a particular social institution. Thus, in a hospital, doctors and patients monitor their own behaviors as well as each other's.

- Multiple interpretations: The researcher should examine the viewpoints of multiple stakeholders. For example, in the ANT framework, objects are texts that are discursively understood. Objects, such as records, are interpreted in different ways depending on the positions of the observers within the network (Dant, 2005).
- Suspicion: In hermeneutic-based studies, the researcher examines narratives for "biases and systemic distortions" (p. 72). According to Klein and Myers, the principle of suspicion is not applied often in information studies research literature. However, critical social theory (e.g., Habermas, Foucault) and feminism (e.g., Haraway) offer frameworks for examining instances of power in language and other types of discourses, such as visual media and historical data. Paul Ricoeur (1970) coined the phrase, "hermeneutics of suspicion," in describing Freud, Marx, and Nietzche's work to examine critically religion as a type of naturalized discourse. Foucault (1984) further developed this hermeneutics of suspicion in his response to Roland Barthes' work on the death of the author. He challenges the importance that Western society places on "authors" and "works" as discrete units, when they are instead culturally mutable ideas serving various discursive functions. Discursive work, Foucault argues, is the basis for all human

inquiry, including science: "the work of initiators of discursivity is not situated in the space that science defines; rather, it is the science or the discursivity which refers back to their work as primary coordinates" (p. 116). For researchers using interpretivism, suspicion of discourse allows them to look beyond who is speaking and into the production of discourse itself. As Foucault poses it, "What are the modes of existence of this discourse? Where has it been used, how can it circulate, and who can appropriate it for himself?" (p. 120). I discuss the importance of suspicion as an epistemological principle further in the following section.

METHODS

The following three subsections explain the methods and research workflow I use to address my research questions. The first subsection is about my research design, which I based on grounded theory and, specifically, situational analysis. I describe the three types of discursive mapping for situational analysis and how they were implemented in my study. The second subsection illustrates my three main data sources for this research: the LPH archival records; the staff, archivists, and researchers tied to the LPH records; and my research memos. I describe the records from the archival collection that I selected for analysis. Then I provide the question prompts that I developed to guide my semi-structured interviews. Finally, for the process of memoing, I discuss the reasoning behind it and my journaling method. The third and last subsection is on the analysis and interpretation of the data. I took a "social actors approach" to critical discourse analysis for both the selected records and the interview data. This method of analysis is particularly well-suited for examining non-human actants involved in discursive actions, and is reflected in my coding practices for the dissertation.

Research Design: Situational Analysis

My study aims to examine the evolving discursive networks between mental institution records and the surrounding actants and actors, especially in regard to the

perpetuation of power structures in which the records and others participate. I am conducting this research in order to identify the stakeholders of health care records and how records as archival objects can continue to affect those actors over time. Looking particularly at the past and current inequities perpetuated in and through the records can inform if and how sensitive archival records should be accessed. As an activist archival scholar, I believe I can mitigate the power biases within the records by identifying them in my research and offering alternative uses for the records to emergent user communities.

The methodology of my study is interpretivist grounded theory. In grounded theory, "data form the foundation of our theory and our analysis of these data generates the concepts we construct" (Charmaz, 2006, p. 2). Typically, the researcher sorts and compares her data by applying codes, or categories, to parts of the data. Data collection and analysis occur simultaneously, and each phase of analysis is subject to the constant comparative method, which is the creation, integration, and definition of categories, followed by the development of emergent theory (Dey, 1999). Research is finished once theoretical "saturation" is achieved, or when no new categories or relationships emerge (Glaser and Strauss, 1967, p. 62). Glaser, trained in quantitative positivism, argued that grounded theory was a method for researchers to achieve objectivity and pure data in qualitative research. While Glaser, in his later career, applied positivistic assumptions to grounded theory, others took the approach advocated by Strauss, who trained in pragmatism-based social interactionism and believed that all meaning was rooted in human agency and language, and therefore was determined by an individual's social surroundings. For Strauss, the researcher and her experiences are significant factors in what data are found and how they are interpreted. His later collaborations on grounded theory (Strauss and Corbin, 1990) involved the development of explicit codifying strategies; Glaser (1992) criticized this method as forcing data into preconceived categories, rather than letting themes emerge from the data.

Although Strauss shifted to a research method with greater reflexivity and acknowledged subjectivity of the researcher, Haraway (1988), who received her doctorate in biology before focusing on information and technology studies, warns against accepting subjectivity as a default epistemological stance because "the 'equality' of positioning is a denial of responsibility and critical inquiry" (p. 584). Researchers such as Adele Clarke (2005) and Kathy Charmaz (2006) have been critical of both Glaser's and Strauss' branches of grounded theory. As an alternative, they argue that "theory neither emerges nor is discovered, instead it is constructed" (Allen, 2010, p. 1,614).

My methodology is adapted from Clarke's (2005) situational analysis. She developed this method as a response to early grounded theory. As an offshoot of Strauss' grounded theory and symbolic interactionism, situational analysis encourages the researcher to look not only at action, but also to apply Clifford Geertz's "thick description" to discourse, voice, texts, nonhuman materiality and symbolism, dynamics of historical change, and power in order to achieve "thick analyses" (xxiii). Clarke's emphasis on multiple discourses, whether historical, visual, or narrative, is particularly important to my own work, which focuses on records as actants in discursive networks over time with patients, staff, archivists, patient families, and other stakeholders of mental health records. My intent is to examine the relationship between records within institutional hierarchies and people in those hierarchies with little or no recorded voice, such as staff members and patients. In particular, I look at how records have the potential to encourage or inhibit inequity for minority groups such as African Americans and the mentally ill and handicapped.

For this research, I have adopted an activist approach that fits within a current postmodernist trend in archival studies that acknowledges the power of archives and the archivist, and encourages the proactive building of archives and archival communities through collaboration and negotiation (Ham, 1975; Upward, 2000; Cook, 2001; McKemmish, 2002; Huvila, 2008; Shilton and Srinivasan, 2008). Activism integrated into the research process can also be considered feminist research, which Donna Haraway

(1988) argues calls for "a better account of the world" (p. 579). The feminist researcher/observer acknowledges her situated knowledge and specific vision, and then attempts to understand the mechanisms behind visual systems (i.e., epistemologies) used in a society to view the world "objectively." In a move away from Glaser and Strauss' traditional grounded theory tenet of "letting the data speak for itself" and allowing social themes to emerge, Clarke (2005) advocates activist research designs that require researchers to embrace the notion that they are the ones constructing the data through their own questions and methodologies. By having awareness of hermeneutic circles, researchers can recognize their own limitations as observers, and then develop research questions that focus on typically unexamined people, actions, things, or places. Clarke argues that good researchers must design their research to account for "underdeveloped" areas of study (p. 76). As a result, researchers can examine previously unacknowledged topics such as emotional work (Hochschild, 1983), race, or gender, all of which might otherwise continue to go unstudied empirically or discussed in larger, non-academic social spheres.

A primary component in the situational analysis process is the creation of discursive maps. During the time I collected and analyzed data, I created situational maps that aided me in identifying the actions and positions of actors within the LPH record ecologies. Clarke argues that a researcher can systematically determine the key actants who take part in one or more social arenas by making her analytic focus be "commitment to action" (p. 113). The focus on actions, rather than physical locations or functions, for instance, allows the researcher to look at how both human and non-human actants move across social worlds by means of discursive practices. I would add that this approach to data collection also encourages the researcher to consider the effects of temporality and digital technologies as agents within ecologies. Clarke (2005) presents three types of mapping that can assist researchers to better understand relationships among actors.

- Situational maps present the major human, nonhuman, discursive, historical, symbolic, cultural, and political components within a "situation of concern" (p. 87). The initial version of such a map is simply a free form presentation of any element considered pertinent by both the researcher and by those within the situation. Figure 2 is an early example of a situational map for my project.

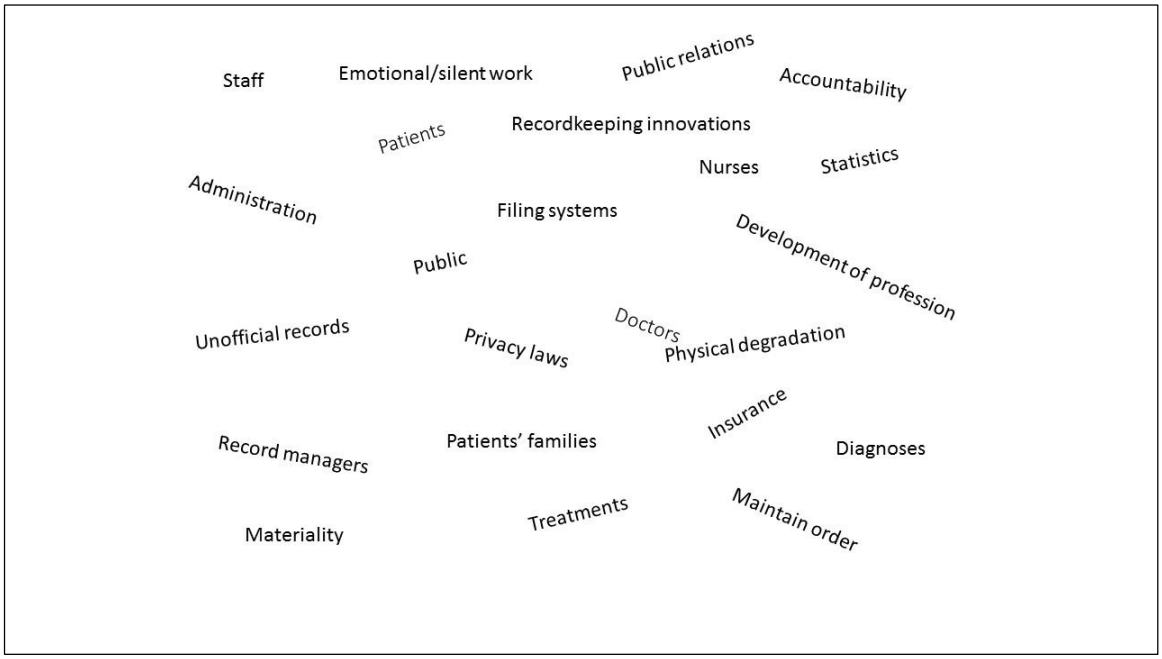


Figure 2: Messy situational map (partial) of records work in mental institutions.

These messy maps serve as a visualization tool for relational analysis, in which the researcher picks a particular element (e.g., nurses, materiality) and describes its relationships to the other elements. It is also possible to create an ordered situational map by grouping the elements by type, such as nonhuman elements, collective human actors, and temporal elements. Figure 3 is the previous map organized by element type. Note that some elements can be in more than one category.

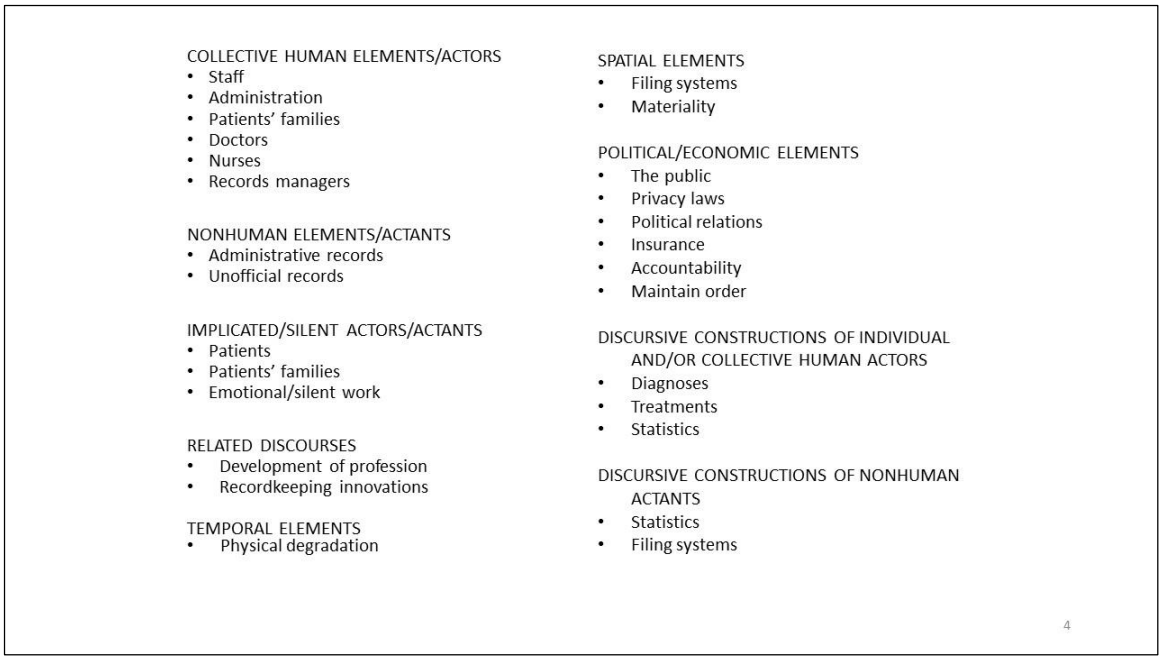


Figure 3: Ordered situational map of records work in mental institutions.

- Social world/arenas maps, an analysis technique that Clarke developed from Strauss' work, examine the negotiations that make up the universe of discourses in a particular collection of social worlds, or what I would call ecologies, within the arena being studied, e.g., the hospital, mental illness. My primary social world map is the Larch Point Hospital records arena, since the records are the focus of my study. As the researcher, I create visualizations that show the social actions at a "meso-level" of analysis (p. 110). Each map shows collective actions across social worlds and, over multiple maps, across time. Collective actors, key nonhuman elements, and arenas of commitment emerge, and help the researcher determine the important narratives to examine further. When mapping focuses on action and who or what is creating discourse, power inequities can become evident. For instance, in discussing what is absent from social world/arenas maps, Clarke emphasizes that "any set of people diagnosed with particular conditions and patients in general are not *collective* actors" (p. 122) but are rather implicated

or silent actors because they often lack shared commitments for action (the exception being patient advocacy groups). The absence of patients in arena maps highlights how medical professionals and patients are differently situated in the medical environment; individuals in the latter group generally do not have the opportunity to create common goals together because of the tacit expectation within hospitals that patient privacy is of utmost importance.[41] The following are two social worlds/arenas maps that together illustrate the changing actors involved in the LPH record arena when the records go from being in use at the hospital to being archival documents. Note that these particular maps are not time specific other than to show the shifts in actor relationships when focusing on active records and inactive ones. Although some collective actors are the same (e.g., administration), their purposes, discourses, and actions change.

[41] An exception to the concept of patients not being collective actors can be seen in the for-profit company, PatientsLikeMe, which began in 2004 as a means for individuals to electively share their health information with others who are suffering from similar health problems: http://ww[w.patientslikeme.com/

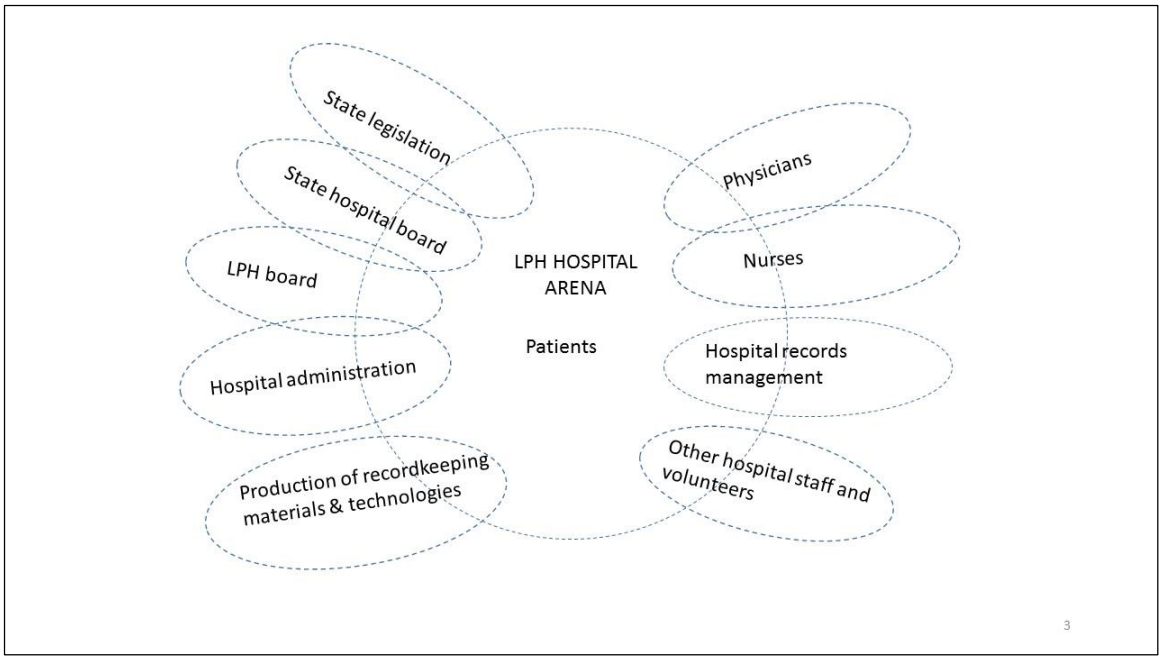


Figure 4: Social world/arenas map of LPH active records.

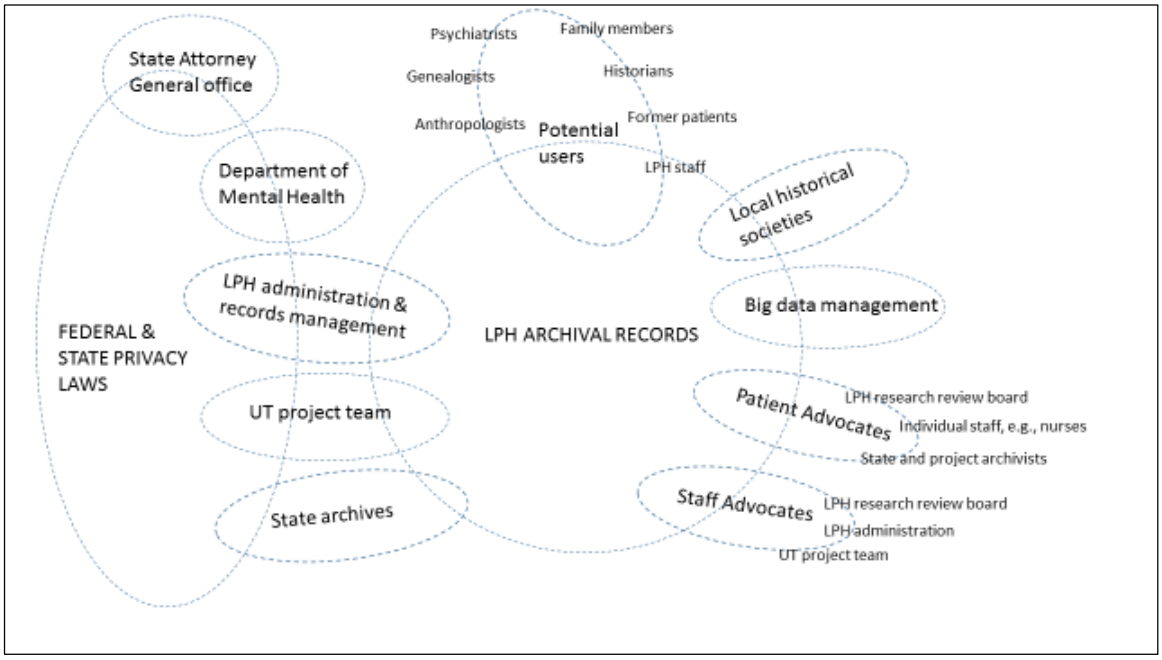


Figure 5: Social world/arenas map of LPH archival records.

In Figure 4, patients are silent actors at the center of the arena because they are one of the foci, or subjects, of record creation and recordkeeping. Patients generally are passive participants in the record creation process in that while they may describe their symptoms or their bodies exhibit signs of illness, it is the medical personnel who create the records. The staff use their medical training, batteries of tests, and prescribed procedures to interpret the patients' words and bodies. Patients can at times be more active co-creators of their own medical records, but in the records, their voices are always filtered through medical and institutional discourse that is outside of their control and knowledge. In Figure 5, former patients are not currently active voices in the LPH archival records arena, but those that are alive and the subject of more current records are potential users of the collection. There are also other collective and individual actors who are part of the social world of LPH archival records. Each actor has a stance regarding the extent to which patients' information from historical mental health records should be made available in a digital archives. For example, the LPH research review board is primarily interested in protecting patients' privacy, while the UT project team is more concerned with balancing privacy requirements and ethics with broadening access digitally and to more audiences.

- Positional maps (not illustrated) show the range of discursive positions on particular issues. These maps help analyze discursive data, and therefore can be disarticulated from sites of production in order for analysis to take place. The map consists of two axes, each of which represents a qualitative range of "less so" to "more so" (p. 128) for a stance on a particular topic (e.g., stated importance of race, viewpoint of race as cultural or biological). As an example for my research, I could have a positional map for both interview and archival record data in which one axis represents "significance of records as cultural heritage" and the other as "level of interactions with patients." The subject matter addressed and the extent to which I will use positional mapping will depend on the initial positions that I

construct from the coded data. It is unlikely, however, that I will develop positional maps for this research because of the complexities and multiple factors that underlie actors' positions, and cannot be easily visualized in a two-axis chart.

Data Collection

I conducted interviews and examined the existing archival records from January 2013 to September 2014 in order to create a dataset. However, my data collection began with my initial involvement with the LPH project in 2010 when I processed the in situ historical records. From that point forward, I was engaging both current record department staff members associated with the hospital, and with retired administrative and medical staff members affectionately called "the old-timers" by a staff administrator. Over the course of the past few years, I have also had many hours of interaction with the legacy records, especially in terms of handling and organizing the materials, developing a finding aid, collecting metadata, and considering the records' materiality and textual properties. In order to keep track of my own experiences with the hospital, its records, and the people I meet, I have been writing down my reactions, recollections, and reflections. These memos or journal entries are particularly valuable for recalling when and how I constructed themes from the data and situational elements during interviews (e.g., location factors, emotions, and body language). Through memoing, I was able to practice dialogical reasoning and examine my own assumptions in relation to what I am seeing in the records and hearing from my interviewees and other actors.

By using both the archival records and interviews as my principal data sources, I studied how records created from LPH's inception to 1970 have played a part in the hospital environment throughout the history of the hospital and to the present day. What remains of the hospital's inactive records, however, can provide only partial insight into how actors and actants interacted and worked together. Therefore, it was critical for me to talk with individuals who could contribute personal narratives that describe record creation and recordkeeping practices, as well as events and changes at the hospital that

are not explicitly discussed in the official records. While I initially struggled with how I would bridge the data from historical records to the oral narratives, once I began my analysis, it became clear that the themes remained the same; it was the perspectives that changed. The following subsections further specify the types of data that I collected: records, interviews, memos, and what is missing.

Records

The historical, or legacy, records selected for this study range in creation date from 1868 to 1970. In grant proposals and public-facing documents that described the LPH archival project, the archival collection is said to cover the same time period. However, at present, the collection in actuality does include more recent board minutes, annual reports, admission registers, images, hospital newsletter, and financial records. The most recent document, a correspondence about hospital commemoration, is from 2010. All documents that were collected by LPH staff in the late 1990s to early 2000s for the archival collection were included, regardless of date or genre. The bulk of the paper-based collection is from the earlier years of the hospital, though, reflecting the gradual transition from paper to electronic recordkeeping systems. Furthermore, LPH staff members who were gathering records throughout the hospital recognized the commemorative symbolism of the 100-year period that began with the hospital's inception at the end of the Civil War to its desegregation after the Civil Rights Act. By indicating that the end point of the collection is 1970, if only in grant proposals and not in the actual collection, the archival project members including myself are attributing some historical weight to the more modern records, which still fall under HIPAA and the state records code (and are therefore restricted if they contain privacy-related information). On the other hand, the deliberate truncation of the collection at 1970 gives the appearance that LPH's history stops at that point, when in fact hospital operations and the creation of records continue to this day. The blurry delineation between what is "old enough" and "historical" goes hand in hand with the incongruous legal and personal stances on what

should be made publicly available – I discuss the challenges of negotiating time-based privacy restrictions and access policies in my analysis chapter.

For the dissertation, I examined two groups of records from three different eras in the hospital's existence. I spent approximately 175 hours reading a selection of archival records in order to collect data on material and textual changes over time. Material shifts include new recording technologies and physical media. Adoption of ostensibly faster, more accurate, and more comprehensive recording tools result in changes to both record formatting and the information being conveyed. Textual shifts are the changes in semantics and diction choices. Adjustments in recordkeeping practices to accommodate administrative needs, developments in the medical field, and multiple record keepers can all affect what is written.

The three eras I used for my dataset are: LPH's early years (1870-1885), the tail end of the Progressive era and the height of its effects on state hospitals (1925-1940), and the period of greatest patient overpopulation followed by desegregation at the hospital (1955-1970). I selected these three periods because of the significant social, political, and medical activities that were occurring in the state and nation, and the subsequent influences on hospital practices and policies. The World War I and II years are notably absent from my dataset selection, but based on my knowledge of the LPH materials that I gained during archival processing, the psychological impacts of combat on veterans continue to manifest themselves many years after the wars are over. I chose to examine a fifteen-year span for each era because I wanted to have a substantial amount of data without being overwhelmed. In retrospect, the fifteen-year spans were overly ambitious, and ten-year spans would have sufficed.

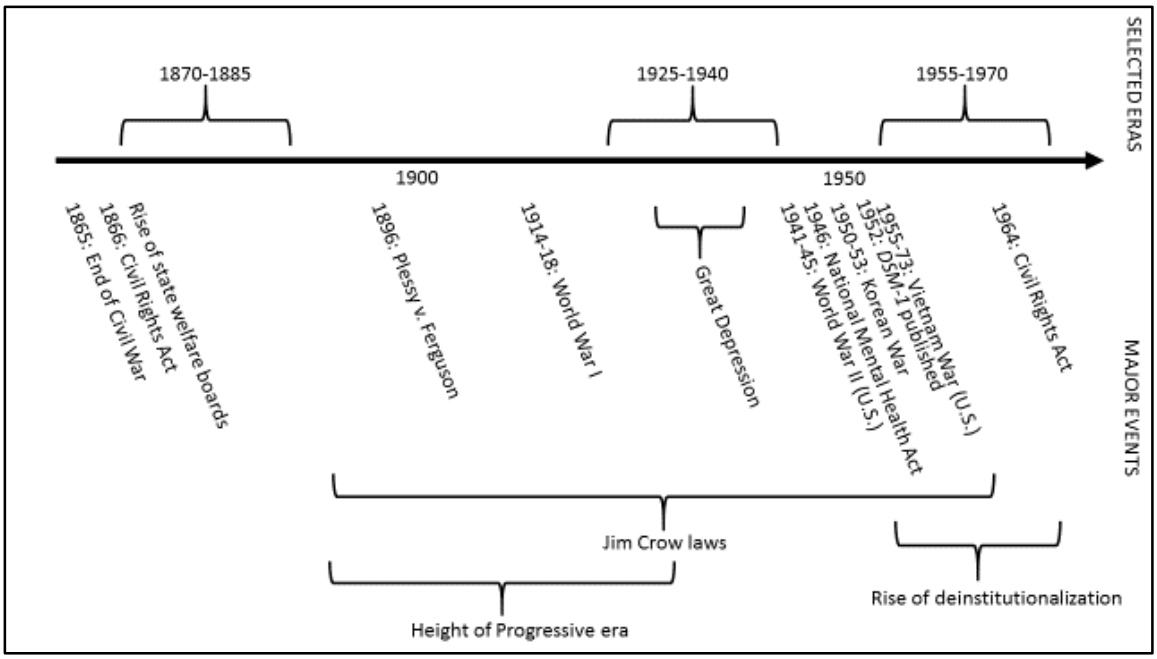


Figure 6: Selected eras of LPH records in comparison with significant U.S. and world events.

I collected data from two genres of records in the collection, patient admission registers and board meeting minutes, which helped me gain insight into the medical side of hospital operations and high level administrative work, respectively. The data from these two genres illustrate how records are part of the discursive work to define two types of bodies: the human body and the body politic (Berg and Bowker, 1997). Thus, while the registers primarily mediate how patients are represented and perceived, the minutes chiefly participate in the identity, structure, and organization of the hospital.

The registers, unlike case files, are bound volumes that list incoming patients and their demographic, medical, and administrative characteristics. Administrative information typically included dates of admission and discharge, legal status (e.g., civil or forensic), and furloughs. While some categories are constant throughout the hospital's history, other categories of information changed over time, reflecting developments in recordkeeping requirements, relationships with other state facilities, and psychiatric theories and practices. I am particularly interested in what I call the registers' informal

categories, which are the columns created by a record keeper to accommodate a new recordkeeping need. These columns are either unlabeled or labeled by hand, rather than the preprinted columns created by the local printer. The informal categories demonstrate how the hospital, and specifically its record creators, negotiated changing information demands. They reflect what has become important in the eyes of the hospital and worthy of being written down and therefore remembered.

The board meeting minutes present another facet of and perspective on recordkeeping: the hospital and state board administrations. For the first two eras that I examined, 1870 to 1885 and 1925 to 1940, the meeting minutes are for the LPH Board, which consisted of a group of men who had an interest in the successful operation of the hospital. The men were typically local politicians, doctors, and lawyers. The LPH Board meeting minutes are handwritten in large leather-bound volumes that were created by local bookbinders. The majority of the content of the hospital's board minutes reflect the often mundane day-to-day operations necessary to run a state facility. They always mention the superintendent's monthly report on the state of the hospital. The superintendent generally attended the meetings and presented his report verbally. He would provide numerical reports of patient characteristics such as admissions, discharges, and the wait list of individuals for admission. Deaths were also reported and explained. Other topics included building construction, financial requests, and the farming report, which was often presented by the head farmer and noted the average number of male and female patients who served as laborers each month (e.g., "Average No of Laborers. 66 Males. 38 Females"). The earliest meeting minutes focused on the establishment of a permanent site for LPH, as the state was leasing land from a former slave trader who ran a private jail (and presumably also a holding area for slaves) in the 1830s and served on the city council through the Civil War; the hospital board encountered a great deal of opposition from his heirs who wanted the land back. The Board also handled a number of disputes regarding the mistreatment of patients, including deaths, injuries, and pregnancies.

The existing board minutes for the 1955-1970 period are for the State Board, which includes the superintendents of all the public mental hospitals in the state and a group of individuals vested with the management of mental health facilities. Unlike the previous era's minutes, these minutes are typed and in loose leaf form. The advent of the typewriter for creating the final version of board meeting minutes appears to have led to more details and verbatim conversations from the meeting being recorded. However, by the 1960s, the length of the minutes shortens to four to six pages. The reason for this change is unclear, but I speculate that this is due ironically to the state mental health department opening its records to the public; as a result, discussion details and sensitive subject matters were often not included in the documents. The State Board meeting minutes in the LPH archives are photocopies, many of which were the copies given to the LPH superintendent or steward who attended the meeting. The vast majority of the business discussed at these State Board meetings during the 1950s are what I viewed as mundane municipal, money, or construction matters.

The 1955-1970 era is marked by the national movement toward deinstitutionalization and the rise of community/family care, e.g., homesteads and, later, community clinics. At the start of this period, LPH is without a superintendent and a sufficient number of doctors. In order to ameliorate the medical staffing shortage, a LPH superintendent in the 1960s developed nursing and doctor internship programs, with the hope that it would attract young medical students by giving them experience and allowing them to get to know the institution. Nevertheless, the attraction and retention of doctors remained challenging for LPH and the other state mental institutions because of the relatively low salaries compared to those for doctors in private practice. State mental institutions furthermore had a reputation of being primarily for custodial care of the elderly rather than offering newer and more innovative psychiatric treatments for the mentally ill. This time period also saw the growth of social work and occupational therapy as fields, and an increase in facilities and programs for mentally disabled children and adults.

Interviews

Finding the silences that occurred during record production (i.e., what was never recorded) and during record appraisal (i.e., what was thrown out) has been my primary challenge when examining the LPH records. How does one discover and discuss what is unwritten or destroyed? Part of the solution is looking toward the larger historical context surrounding the hospital and its activities. Significant events such as the passing of Jim Crow laws, the Great Depression, and the Civil Rights Act affected the daily routines at LPH even if these larger events were not mentioned very often or at all in the hospital's records. The record creators made assumptions that their intended audience knew about the events going on around them, and therefore the records reflect the hospital's reaction to those events. The records can offer glimpses into discussions and decisions that were not preserved. They are, in fact, often the result of these discussions, reifying the idea that their original purpose is not to provide historical insight into the hospital but to serve as official documentation to fulfil reporting requirements. Thus, for example, the Great Depression is only mentioned twice in the hospital board minutes; it is in the context of external pressures on LPH administration to stretch the hospital's financial resources both to improve hospital conditions and to help the local economy.

It is impossible to reconstruct the lives of patients based on what is found in the admission registers alone. Even with the addition of case files, the personal histories of patients before they came to the hospital and after they leave remain a mystery. Their relationships with the medical staff and their daily routines at LPH are also not portrayed in the records. While these lacunae can be frustrating for archivists and researchers, they also present the opportunity to explore other means of interpreting the lives of the hospital's silent actors. Collecting oral narratives is a partial solution for addressing gaps in the written record. For the purposes of this study, it was neither feasible nor logical for me to talk with former patients, but it did make sense to talk with current and former employees who were record makers and record keepers. Their lived experiences are not explicitly seen in the records, and, by telling their own stories, these individuals are

providing perspectives on hospital life that can help attenuate some of the documentary gaps of what was never recorded and what was destroyed in situ. As noted by Berg and Bowker (1997), "there are many steps between 'what happened' and the final record" including "the often invisible but crucial pool of typists who transform the physicians' taped reports into legible, grammatically correct and understandable reports" (p. 523).

For the interviews, I talked with individuals who had ties with the archival collection, whether they created, manage, or want to use LPH records. In total, I recorded ten and a half hours of interviews. I interviewed six current or former LPH staff members, one archivist, and one academic historian. As the LPH project archivist at the hospital processing the collection, I become acquainted with a number of the administrative and record management staff at the hospital. In 2010, I conducted two one hour-long group interviews at the hospital with staff and former staff as part of two luncheons. These initial interviews were helpful for identifying potential interviewees and discussion topics. I determined from these experiences that the hospital setting arguably discouraged candidness, and I aimed to conduct future staff interviews outside of the institution. Furthermore, while group interviews can lead to more lively and varied discussion, this was not possible due to the LPH research review committee's requirement that all interview subjects be anonymous in the dissertation and ostensibly to one another.[42] I should note, however, that several interviewees know about one another's participation in my research because of the snowball sampling and their openness with friends and colleagues about their involvement. Per my agreement with the research committee, both the hospital and all interview participants have pseudonyms in my dissertation. In order to make my research as collaborative and participatory as possible while also adhering to my LPH agreement, I gave all interviewees the option to

[42] An exhibit that utilized group oral narratives can be seen in "Changing Face of What is Normal: Mental Health," in which former Willard Psychiatric Center staff were interviewed: http://www.exploratorium.edu/visit/west-gallery/whatisnormal

be recorded in any way they preferred. I also performed member checking so that interviewee had final approval of their transcripts; as a result, they had control over their narratives to as great a degree as possible while allowing my research proceed. While all participants agreed to be audio recorded, only a few were willing to be video recorded.

I interviewed individuals who have substantive connections to the hospital records, albeit from different institutional and personal contexts. I sought two additional people for interviews, but they did not respond to email. Here are brief, generalized descriptions of the participants that I interviewed between September 2013 and September 2014:

- Loretta M.: Retired administrative employee who worked at LPH for 30 years starting in the late 1970s, and held several positions, including clerk aide, clerk typist, admissions clerk, and information release coordinator
- Cathy R.: Retired nurse who worked at LPH from the late 1950s to the early 1990s
- Betty T.: Retired clerk stenographer and administrative assistant who worked at LPH for 50 years, starting in 1960
- Robert L.: Retired administrative employee who worked full-time at LPH for 25 years starting in the late 1980s as an assistant administration director, and now currently works part-time at the hospital
- Janet S.: Current high-level hospital administrator who has been at LPH for 15 years
- Dennis H.: Current doctor at LPH who has worked there for 15 years
- Ann P.: Former archivist at the state library who processed multiple state mental facility collections in the mid-2000s, including the small LPH collection given to the state archives
- Henry A.: Social history professor who uses 19th- and 20th-century medical records to study African American mental illness.

During the planning phase for my interviews, I initially intended to meet with each interviewee at least twice. Later, I found that most of the first interviews concluded at points that did not warrant follow-up interviews that would involve additional travel for me. If I had any further questions, I was usually able to contact the interviewee for clarifications using email. Each interview typically lasted one to two hours, depending on the participants' schedules. When I met with each interviewee at a mutually agreed upon location, I discussed with the participant how our discussion would be recorded, e.g., audio or video. We also looked over the consent form, and the interview participant was able to ask me any questions or raise concerns that she may have. The interviews were semi-structured. I came prepared with an extensive list of questions, but I found that I did not refer to them during the interview (see Appendix A for the list of questions). Generally, each interview began with me asking about the interviewee's professional background and how she became involved with LPH. Then, we would focus on her daily workplace practices, with a particular emphasis on records work. We would next discuss what she thought of the historical LPH records in terms of privacy, preservation, and access. I tried to end each interview by asking the participant about what she enjoyed the most about her job. During the interview, I allowed the participant to speak at length for as long as she wished. My intention was to have the interviews be co-creations with the interviewees, but I found that the introduction of the consent forms, recorders, and other indicators of an interview setting had a tendency to make the meetings feel more formal and less conversational. Time permitting, additional interviews would probably have helped the interviews feel more informal.

Since all of my participants agreed to be audio recorded, I transcribed the recordings using the popular free software, Express Scribe. I decided to transcribe the interviews in their entirety myself in order to be as immersed in the data as possible; I transcribed all but the last interview, which was done by a professional transcription service. I then listened to each interview a second time to make corrections and create memos. Next, I made every effort to reach my interviewees after the interview in order to

present them with transcripts of our conversations to review. Of the eight interviews that I conducted, three responded with edits, three did not respond to my emails, and two were unreachable via phone or email. I made any interviewee-requested changes to the transcripts before creating finalized copies that I coded.

Memos

In order to confirm and maintain confidence in my study, I have been journaling, or "memoing," throughout the data collection and analysis process. The creation of audit trails is common in qualitative research in order to ensure transparent decision-making throughout the research trajectory, e.g., concept developments, chosen methods, and final recommendations (Shenton, 2004). Journaling is particularly important when collecting and analyzing historical discourses; historical research is very different from interacting with speaking and self-aware individuals. Clarke (2005) writes, "Memos are sites of conversation with ourselves about our data" (p. 202). Journals can also serve as data to be analyzed, thus encouraging an iterative process of action and reflection. For my research, maintaining a journal allowed me to contemplate what I had just read or experienced, and to develop themes as I collected my data. It was a place to describe my interactions with information that I encountered and my intellectual and emotional responses especially at the beginning of new document genres or eras. For example, I found the examination of the early patient registers to be exhausting. On my second day of data collection, January 17, 2013, I wrote:

> I am finding it difficult to look at patient records for long spans of time. It's fascinating, but also overwhelming, shocking, and sad, to read about so many people in such a short amount of time. I only know snippets of these people's lives and how they were perceived. Today, I was particularly struck by all of the violence in the texts, whether the words used to describe a person's illness (or "attacks"), the harm done against the person (patient against patient violence, domestic violence), or the injuries that the patient inflicted on others or himself. Some of the apparent causes of insanity were also strange to me, as a researcher in the early 21st century. Causes such as love, financial anxiety, and loss of

> property almost seem ridiculous. Certainly those can and do cause woes, but insanity? And enough to warrant someone to be institutionalized with people who have actually killed others? Some of these patients "recovered" and were discharged after a year or two. But others died at LPH, and often to causes that seem unrelated to their initial diagnoses.

Upon reflection now, I believe I was overwhelmed by the uncomfortable realization about the kind of information that would become the basis of my study and the amount of it. I would not be able to examine in-depth the lives of individual patients, their community, and families; rather, the data were going to be thousands of one- or two-sentence synopses about illness. In the early records, these summaries often covered decades, and in later registers, they revealed nothing between admission and discharge or death. Reflecting on these gaps or silences in information about patients' lives helped me better understand for whom the records were written and for what purposes. The bureaucratic nature of a state hospital emerged from the recordkeeping. Until I began conducting interviews, I did not get a good sense of the humanity of the hospital, and the individual relationships that had developed there.

Memoing also helped me expand patterns I saw in the data, changes over time in the records, and one-off remarks that I explored further with secondary sources. It was a means to make connections between the data and other texts, e.g., histories, ethnographies, studies. It is one thing to read about the Progressive era in medicine and another thing to see it play out at my research site through its records.

What is Missing

In addition to board meeting minutes and patient registers, I would like to have included other record genres in this study, such as photographs and case files. In my dissertation proposal, I intended to analyze LPH photographs across the three eras. I decided not to conduct full analysis on the photographs, however, because of time prohibitions and the fact that, unlike the registers and minutes, the photographs are not well-represented across the three eras. This unevenness is of course an artifact of the

history of photographic technology and its eventual popularity and affordability by the mid-20th century for state institutions and individuals, which in itself could be a focus of study. I will note that at LPH, the few photographs during the hospital's early years were used for formal administration group portraits, new buildings, and large group images of patients outside performing a variety of activities (e.g., farming, at leisure, playing baseball). The LPH archival collection has no dated photographs from 1925-1940. This is not to say that there were no photographs taken at the hospital during this time period, but they are either undated or have disappeared.

An enormous increase in photographic records occurs in the final era that I examined. The year 1955 is marked by an intensive effort by the hospital administration to record the exterior and interior appearances of new and old buildings, staged hospital procedures, daily practices for patients, and special events that took place on the LPH grounds. The bulk of the LPH images from this time period were hand stamped to indicate they were taken by two local professional photographers. During this time, the hospital appeared to be undergoing increased public scrutiny and criticisms from state politicians. The hospitals were overcrowded, understaffed, and necessarily focusing more on custodial care than mental health care. The State Board itself was promoting family care environments as an alternative to the state hospitals, as stated in the May 1956 minutes: "The Chairman suggested that every effort be made to get more of these people out of the hospitals and into family care." The need for LPH to justify its continued existence would explain the proliferation of photographs being used to provide evidence of hospital conditions.

By the 1960s, film and audio were also increasingly being used as media to convey to the public a positive image of the hospital:

> [The LPH superintendent] reported on the press conference held at Larch Point Hospital on Tuesday, April 25, 1967. Various officials and members of the press, radio and TV were given a tour of the hospital in order for them to see that it was not a 'deplorable' hospital as intimated in recent criticisms of LPH. [The superintendent] said they went away with a better picture of the hospital.

Audio-visual media are particularly well-suited for publicity purposes. They can immediately reach the public through several mass media venues such as newspapers, radio, and television. Photography historian Estelle Jussim (1989) view photographs as "a paradoxical mix of information and persuasion" – thus, what may be perceived by a viewer as objective reality could be intended by the photographer as propaganda (p. 159). Audiences of photographs could view the objects as a "reliable witness," but like any other recordkeeping media, photographs only provide evidence rather than are evidence (Yeo, 2007, p. 336). The visual nature of the official LPH photographs from the mid-1950s, for example, allowed people outside of the hospital to infer that what they saw in the image reflected reality. Even a doubtful or cynical viewer of the daily practices at LPH could see that the hospital facilities existed and were in a particular condition. By literally offering a "better picture of the hospital," LPH administration were trying to convey a message to the public that the institution's patients were properly cared for and living in a decent environment.

The hospital's archival image collection also includes a number of Polaroid pictures, snapshots, and slides that were all taken by employees. These candid photos are mostly undated, but appear to be from the 1960s forward. They usually depict groups of nurses, doctors, occupational therapists, and administrative staff posing informally or at work. Some also include images of patients during occupational therapy or during public events on the hospital grounds, such as the popular May Day festival. As the photos and slides are often undated with unidentified people and places, they have limited value as documents for historical research. However, they have potential use as memory stimuli for interviews and artifacts for visual studies. For my dissertation research, I found myself able to make connections between depictions in those photographs and interviewees' narratives about public events at the hospital. The photographs also helped to confirm my inquiries regarding the racial makeup of the LPH staff and patient overcrowding.

In addition to the photographs, I also do not include case files in my dissertation analysis due in part to privacy concerns and to the unique archival processing challenges associated with microfilm. First, I believe my research would have come under greater scrutiny and likelihood of rejection by the LPH research review committee if I stated an interest in using patient files as case studies to examine the changes in patient recordkeeping over time. One interviewee, Dennis H., is a doctor at LPH, noted that it could be fascinating to take ten patients from each decade of the hospital's existence and do in-depth studies of those patients, who they were, what they were diagnosed with, and how they were treated. This idea for a social history study would indeed be interesting, and perhaps can be done one day once the LPH records have been successfully transferred to the state archives with clear access guidelines in place. At this time, however, the restrictions on the records are less defined, especially for me because I am also involved in the archival project. The maintenance of good relations with the hospital administration is more important for me than using particular genres of records, even if no privacy-related information would be utilized.

Second, all of the archival patient file records that I am aware of are on microfilm. They have been digitized, but are not processed. The microfilming and subsequent destruction of the paper-based files have made organizing and differentiating records for individual patients difficult. Rather than single paper-based files, or folders, for a patient, the microfilmed records are lengthy rolls of multiple patient files strung together. Ostensibly, the microfilmed files are in alphabetical and chronological order by admission date, but of course this is not always the case. The digitized files of the microfilm maintain the order of the microfilm, which has yet to be tagged with metadata or separated by each patient's casefile.

Analysis

My analysis is based heavily on the social actors approach sometimes used in critical discourse analysis (CDA), developed among a group of interdisciplinary scholars

including Teun van Dijk, Ruth Wodak, and Norman Fairclough in the early 1990s. CDA assumes that discursive practices are social and situational. Furthermore, "discourse is socially constitutive as well as socially conditioned" (Fairclough and Wodak, 1997, p. 258). In order to reveal discourses of power, control, and hegemony, which are central concerns of CDA, the social actors approach calls for the identification of seven "core elements" in texts (Wodak and Meyer, 2009, p. 30). Not all elements are necessarily available in a given text. Here, I describe what I would look for to satisfy each element mentioned by Wodak and Meyer:

1. Actions: I identify the actions, or practices, that are represented by the text. What is being told? What is the purpose of the text?
2. Performance modes: This element is related to the genre of the text. For example, the text may be a dialogue recorded in board meeting minutes, a written speech, or part of promotional materials intended for a public audience. How are the actions presented?
3. Actors: Theo Van Leuuwen (1996) defines actors as individuals or groups of individuals whose actions create and reproduce social structures. I would include non-human actants, such as the text itself, in this element category. What actants took part in the creation of the text and/or are present in the text, e.g., implicated actors, such as patients?
4. Actors' presentation styles: This element encompasses the means by which actors express themselves. Discursive strategies could include argumentation styles. Linguistic devices may be metaphors, categorizations, and euphemisms, among others.
5. Specific times of the constituted social practices: When was the text created? What is the temporal relationship between the creation of the text and the intended or past actions?

6. Spaces of the constituted social practices: Where are the texts being created? What is the relationship between the geographical location of the textual material and the spaces or places in which the actions described will take or have taken place?
7. Specific resources required by the actors for constituted social practices: Resources can refer to material resources, such as food, money, and equipment, as well as less tangible resources such as time and social rankings. The texts as objects are also resources, and the researcher should consider how the materiality of documents can facilitate social practices.

Using the above elements as my units of analysis, I conducted open coding on the historical records and transcripts from the interviews. See Appendix B for an example of how I applied the core elements to the first patient register (1866-1887). I did not formally code my memos because they are both part of the dataset and my analysis, and would create redundant coding. Nevertheless, memoing was an integral component of my research methods, especially to negotiate findings that challenged my assumptions, and is included in the discussion section.

In order to help facilitate finding and visualizing patterns in the data, I used the qualitative content analysis software, Atlas.ti. This software enables researchers to code their data and conduct analyses such as word frequencies and code co-occurrences. Coding was an iterative process, in which I went through the data several times, developing new codes as I progressed and then going back through the data to apply codes of themes that did not emerge until later. For example, I was relatively judicious in applying codes to the patient register data; I note in a June 18, 2014, memo that "the data from the meetings are more represented than the data from the registers in terms of code groundedness." As I coded the board meeting minutes, however, I would go back to the registers if I developed a code that would apply to those data as well (e.g., patients'

anonymity, alcoholism) that did not appear frequently or consistently in the registers and therefore did not seem to me to be pertinent enough to note in the first pass.

My coding of the text led me to construct discourses. I specifically focused on how the speaker (or, more accurately, speakers, especially if one considers the "institutional voice" and the records themselves as actants) legitimizes institutional hierarchies through properties such as language, materiality, and organization, and on the social implications of this authorization. Institutional texts, which are records of everyday routines and not necessarily created to be explicitly historical accounts, can individually and especially collectively be analyzed to reveal the cultural life of an institution, and how daily practices – including the writing of the records themselves – naturalize and reify the dominant group's control (Van Dijk, 2001; Yates, 1989). According to Bourdieu (1991), language in records can act as "symbolic violence" that quietly perpetuates cultural hegemonies and affects how controlled populations and individuals are treated. I paid particular attention to the categorizations and standardizations of form documents (in other words, one aspect of the records' materiality) in order to deconstruct their "social, political, and philosophical context" (Bowker and Star, 1999, p. 55).

In the parlance of Atlas.ti, "groundedness" is related to the concept of grounded theory, albeit in a more simplistic manner. It refers to the frequency or number of quotations that are associated with a particular code. The qualitative analysis software can also sort codes according to "density," which refers to connectedness or the number of other codes associated with a code. I create the code associations through the software's network function. The creation of a coding network is most useful for visualizing the relationships among the codes. Since I placed each code into only one code family, the ability to connect codes in the network view (and thus create code "density") allowed me to show relationships among codes that extended beyond the code families. I found that, although the density condition provided me a way to measure qualitatively how connected a code is with other codes, for this particular research endeavor in which I was the only coder and therefore did not require intercoder

reliability, the number of connections are somewhat arbitrary because I could argue that all of the codes are connected in some way (e.g., are associated with, is part of, is cause of). If anything, examining code density – as opposed to performing cluster analyses of words in archival records and interviews – is one iteration of analysis too far from the original data.

Chapter 4: Results and Discussion

In the following chapter, I discuss my analysis of the archival documents and interview data. I use passages from my journal to illustrate my discovery process and specific interactions I had over the course of my research with the actants and actors associated with the LPH recordkeeping ecologies. I present my findings thematically to demonstrate the development (or disappearance) of concepts across the three eras I examined. Some of the coded data explicitly relate to records' characteristics or the practice of recordkeeping over time, which informs us of the ways in which records have been and continue to be an active and mediating part of the hospital environment. Data regarding the changes in record forms and how records were maintained illustrate the interplay between the actors' workplace needs and the actants' materiality. Other data that I discuss in my findings correspond to themes that appear frequently *in* the records and the interviews. While not about the physical records themselves or the act of recordkeeping per se, these topics also shape LPH's record ecologies. For example, I deliberately made note of the many instances of race and gender in the data. Hospital personnel recorded decisions and other actions based on race and gender and, in turn, the records had and continue to have influence on actors such as the hospital administration and archivists.

As I noted in my methodology section, my research is most closely aligned with Clarke's (2005) activist research. I approached my data collection and analysis with the intention of examining instances of power and hierarchy, especially through recordkeeping practices. As a result, my coding schema strongly portrays records as participants in the construction and maintenance of a highly bureaucratic and socially restrictive environment. The open coding process resulted in 65 unique codes that range from social structures to actors to everyday activities and events (see Appendix C for the full coding schema). I placed each code under one of 11 code families: changes over time, diseases, external factors, historical events, internal problems, notable individuals, patient types, power, records, relationships, and treatments. The following table lists the

six codes that I used most frequently, and also shows the number of times I applied each code to the interview data and to the archival records data:

Code	Interviews	Records	Total Applications
Accountability	68	116	184
Commentary on recordkeeping practice	132	72	204
Economics	36	170	206
Hierarchy/Power	75	101	176
Hospital conditions	64	118	182
Inter-organizational dynamics	54	146	200
Total	429	723	1152

Table 1: Most frequent codes sorted by data type.

The table illustrates that I frequently applied the dominant emergent codes to both datasets. Economics is discussed noticeably less in the interviews than in the records, which follows the board meeting minutes' emphasis on financial matters. Meanwhile, the frequency of commentary on recordkeeping practice is very high in the interviews since that was a primary topic that I introduced to the conversations.

A cluster analysis of the words from the archival records dataset (which is primarily composed of passages and snippets copied verbatim from the records, but also includes some commentary from me) affirm some characteristics of the recordkeeping environment at LPH between 1870 and 1970. The analysis supports my observation that there was a heavy male-bias in hospital administration and board membership throughout this one hundred year time period. While "he," "his," and "Mr." appear frequently in the data, pronouns and titles for women are much less common. For example, the word "his" occurs 153 times while "her" appears 101 times. The higher frequency of masculine pronouns compared to feminine ones is not due to gender-neutral nouns being referred to as masculine; rather, the masculine pronouns are in reference to male individuals. Meanwhile, the words "female" and "male," which are exclusively used to refer to patients, appear in the data with almost equal frequency at 147 and 135 times,

respectively. Other commonly occurring words in the archival records dataset reflect the collaborative and authoritative nature of the decision-making that is recounted in the minutes: "meeting," "committee," "report," and "said." Analysis of the individual words alone points to the impersonal and official nature of the registers and minutes. As a result of being an outside observer examining the activities portrayed in the LPH records, I constructed themes that tended to be from an etic viewpoint. The codes I developed, such as accountability (which is an anachronistic term for most of the time periods that I investigate), are ones that the I deemed important for my research even if the cultural insiders (e.g., the hospital board) may not have seen as relevant or meaningful. In contrast, the themes that I constructed from the interviews are based on the opinions, reflections, and emotions of individual actors within LPH record ecologies.

During the coding for the interviews, I developed several codes that were infrequently or never applicable to the data from the archival records: ownership of work, staff-patient interactions, preservation, modern records, privacy, and stigma. Two other codes that I developed during the first coding phase of the interviews, nursing and intra-hospital dynamics, were applied to the archival records data during a second pass. I noted in a June 22, 2014, memo how the staff-patient code emerged:

> While there are plenty of staff-patient interactions mentioned in the minutes, they all directly relate to hierarchical/power issues or control over patient bodies – in other words, they always seem *problematic*. But in the interviews, the interactions are usually memorable for the staff member in productive ways that taught the person that the mentally ill are no different from herself. Or else the interviewee talked about patients in a way that is respectful and even with admiration.

The interviews provided personal insight into working at LPH, rather than the more institutional, or administrative, viewpoints that I saw portrayed in the board meeting minutes. By interviewing hospital staff members and other individuals who are part of the LPH record ecologies, I was constructing a set of records that showed emic perspectives, or the viewpoints from within a particular culture. Therefore, the codes that emerged from the interviews reflect narratives about interpersonal relationships between

individuals, personal beliefs, and the interviewee's relationship with records. A cluster analysis of the words spoken in the staff interviews reveals that, unsurprisingly, as a result of my role as a researcher directing the topics of conversation, the words "information" and "records" are two of the most frequent nouns that appear in the interview transcripts. Other common recurrent words that are not prepositions or articles are personal pronouns such as "you," "we," "me," "my," and the conjunction "I'd." These words were not typically used in the archival records. The word "know" also had a high frequency in the staff interviews, and points to the speaker's reflections about her personal experiences and knowledge.

The most interconnected codes, or the ones with the greatest density, are from my etic viewpoint of the LPH record ecologies: hierarchy/power, classification, accountability, and development of psychiatry (for a full map of the networked codes, see Appendix D). I began my research with the belief that power and hierarchy were integral to hospital life. In my research questions, I stated my intention to examine power inequities that were reflected in the records and perpetuated by them. By creating networks of code connectivity, I can qualitatively demonstrate how and for whom power dynamics play a part in both intra- and inter-hospital relationships.

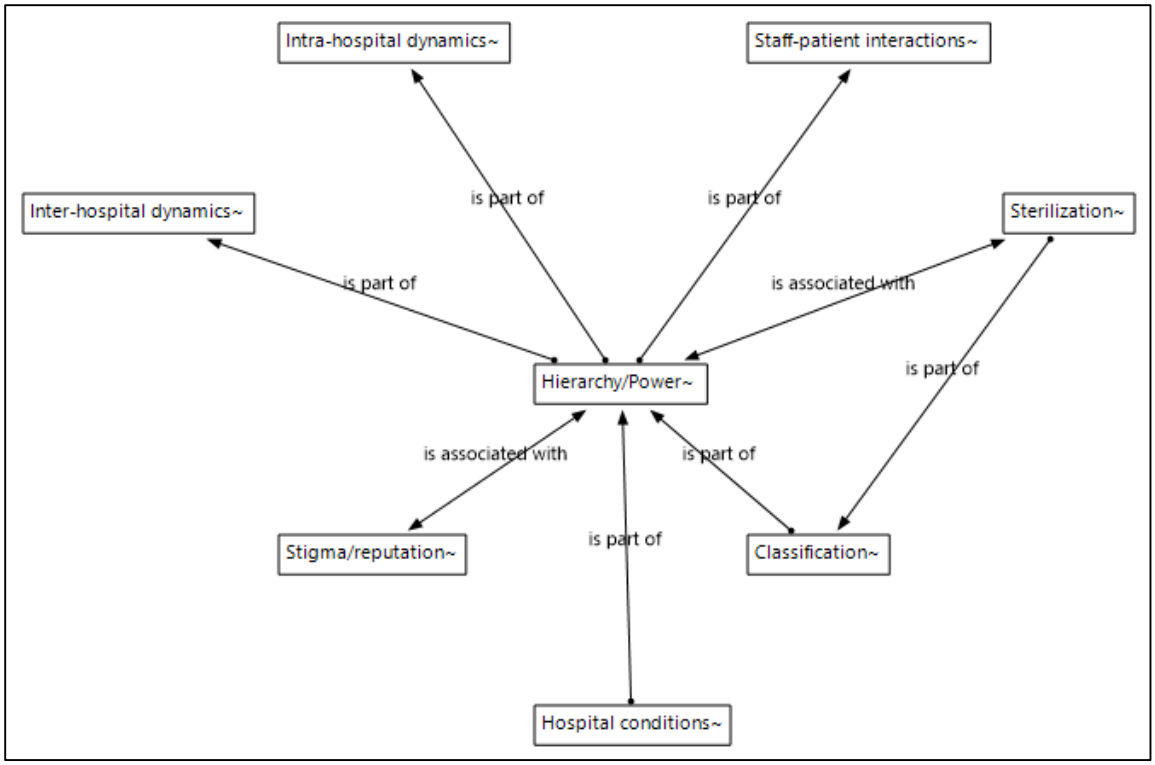


Figure 7: Code density network for hierarchy/power.

Another dense code is classification. Unlike the abstract concept of power/hierarchy, classification is a daily hospital practice directly tied to the act of recordkeeping. The density network for classification shows that other codes such as race, gendered characteristics, economics, education, and sterilization are a part of the act of classification, which is in turn part of the hospital's larger power/hierarchy dynamics.

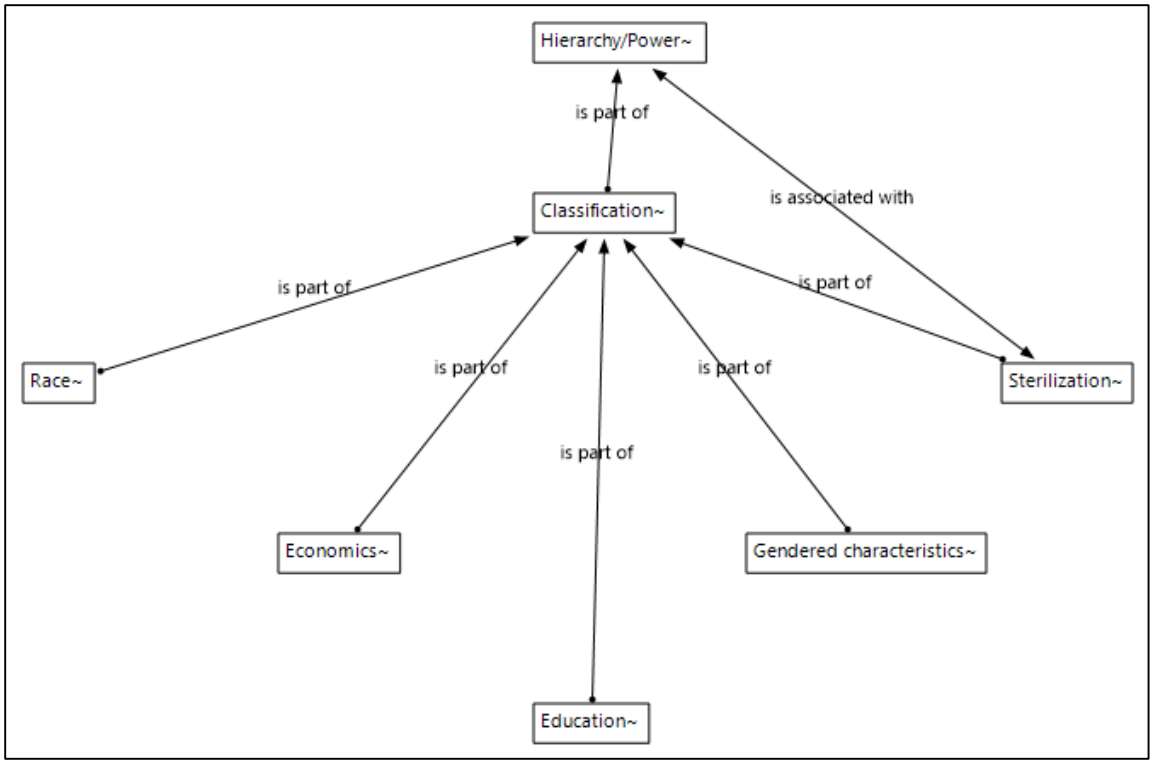


Figure 8: Code density network for classification.

In the following discussion, I have organized my narrative to focus first on the records as material objects (i.e., the way they look and what they are made of) that have been constructed from a confluence of the social, technological, and political. Next, I examine the way in which records served as actants within the social ecology narrative, and especially how the records mediated relationships involving hierarchies and unequal power dynamics within the hospital and between organizations. I look at the interactions between records and people, the purposes of the records, and what was recorded and what was not. Lastly, I talk about the transition of the records to the archives and how hospital stakeholders and scholars perceive the notion of hospital records as archival documents. I look toward the future and discuss the potential for new types of interactions and social narratives between the LPH archival records and emergent user groups with the support of digital technologies.

TRACING CHANGES IN MATERIALITY AND FORMAT

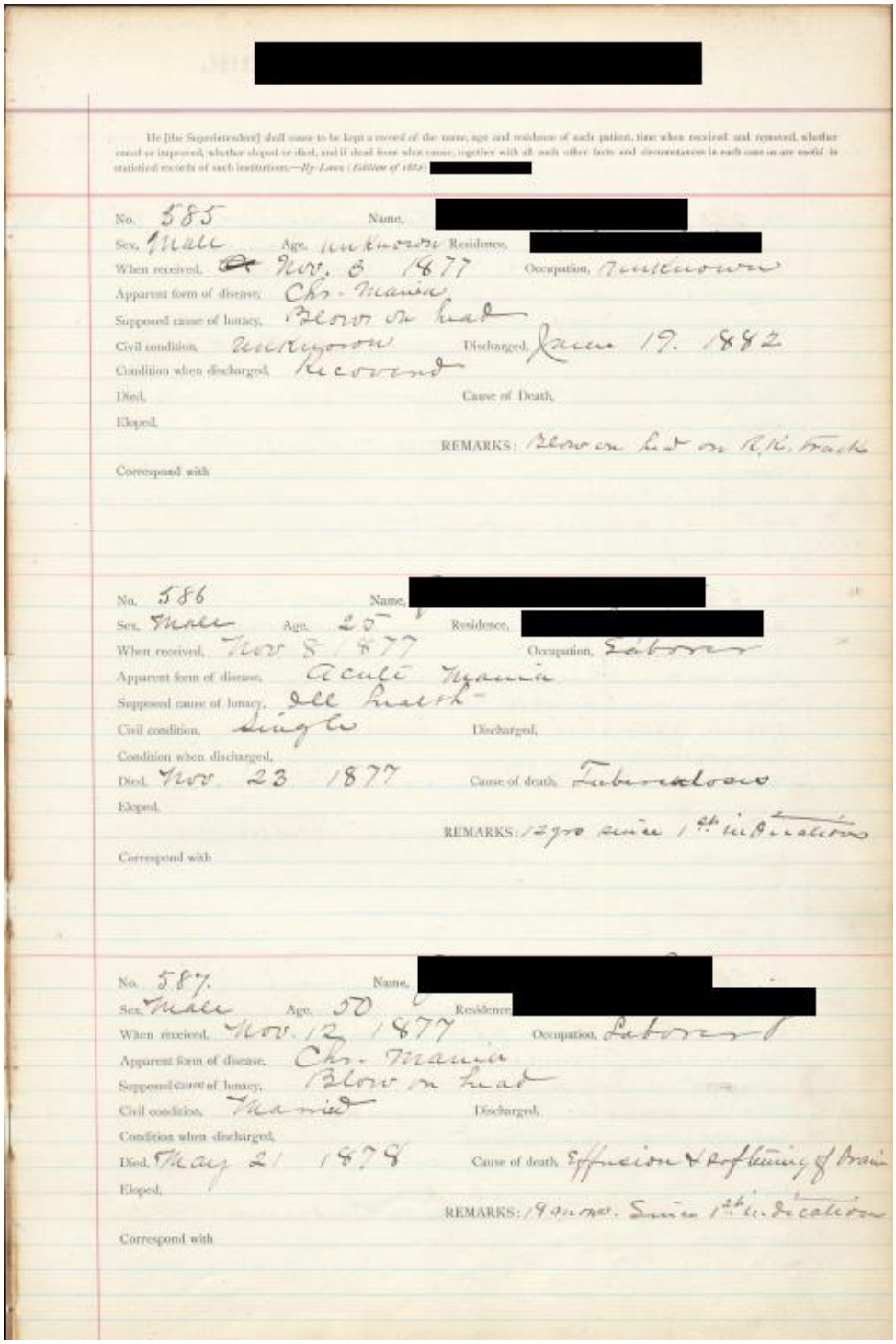
As material culture, the archival LPH records are evidence of one hundred years of hospital practices. While not all of the documents created through the everyday operations at the hospital have survived over the years to become part of the archival collection, the remaining records can nevertheless tell us a lot about the LPH workplace environment through the materials that the records are made of and the corresponding format of the records. The physical characteristics of the records are affordances that can be a static, and therefore constraining, factor on the constantly evolving recordkeeping and medical practices taking place at the hospital (Norman, 2002). The use of bound volumes for both the registers and the minutes give us insight into the notion of what institutional "recordkeeping" was supposed to look like in the 19th century, while the continuing use of these materials (especially for the registers) indicates the influence of tradition and continuity of record formats on the hospital, despite the constant developments in recordkeeping technology and new recordkeeping needs for state psychiatric facilities. The preprinted formatting (e.g., lines for columns, rows, entries, categories) are the product of administrative expectations for recordkeeping at the time the recording media were produced for the hospital. Meanwhile, the marginalia and creation of informal categories demonstrate how the record creators circumvented the limitations imposed by the records' forms. The tensions among technological changes, material constraints, shifting informational needs, and institutional memory can all be seen in a longitudinal examination of the LPH archival records.

Registers

The first patient register I examined covers 1866 to 1887. There are three other existing LPH registers that overlap with this one, but none with such an early start date. The register was not created in 1866, however, but in 1882. An 1882 state by-law is printed at the top of each page. It declares:

> He [the Superintendent] shall cause to be kept a record of the name, age and residence of each patient, time when received and removed, whether cured or improved, whether eloped or died, and if dead from what cause, together with all such other facts and circumstances in each case as are useful in statistical records of such institutions.

The text is an announcement of why the patient register must be maintained and why particular record categories are required. The presentation style in the register for the printed by-law is formal and impersonal. It assumes the Superintendent is always a "He" and that this man is the one who is in charge of keeping the records. No mention is made of who maintains the records. Rather, it is the Superintendent who "shall cause" the records to be kept. The language used to describe patients is passive, in that they are "received" and "removed"; the patients are part of the social ecology of the records, but they are only implicated actors. The reason for the requirement to record major life events (e.g., institutionalization dates, escapes, deaths) comes at the end of the statement; these facts are to be recorded because they are "useful" for statistical purposes. Notably, some of the early patients had already been discharged or died by the time this register was created in 1882. The original source materials dealing with the pre-1882 patient admissions have long since disappeared or been destroyed. This order of operations suggests that a retroactively comprehensive register was important to the register's creators and that the register was not intended for patients' care but for administrative recordkeeping obligations. The events of a patient's life are minimalized. Berg and Bowker (1997) note that medical records compress the changes in a patient's body and mind that occur over days, years, and even decades into "textbook time" (p. 516). While they were referring specifically to case files, Berg and Bowker's findings hold true to an even more extreme degree with the registers.



[redacted]

He [the Superintendent] shall cause to be kept a record of the name, age and residence of each patient, time when received and removed, whether cured or improved, whether eloped or died, and if dead from what cause, together with all such other facts and circumstances in each case as are useful in statistical records of such institutions.—*By-Laws (Edition of 1874)* [redacted]

No. 585 Name, [redacted]
Sex, Male Age, Unknown Residence, [redacted]
When received, ~~Oct~~ Nov. 8 1877 Occupation, Unknown
Apparent form of disease, Chr. Mania
Supposed cause of lunacy, Blow on head
Civil condition, Married Discharged, June 19. 1882
Condition when discharged, Recovered
Died, Cause of Death,
Eloped,
REMARKS: Blow on head on R.R. Track
Correspond with

No. 586 Name, [redacted]
Sex, Male Age, 20 Residence, [redacted]
When received, Nov 8 1877 Occupation, Laborer
Apparent form of disease, Acute Mania
Supposed cause of lunacy, Ill health
Civil condition, Single Discharged,
Condition when discharged,
Died, Nov 23 1877 Cause of death, Tuberculosis
Eloped,
REMARKS: Sym one 1st in Duration
Correspond with

No. 587. Name, [redacted]
Sex, Male Age, 30 Residence, [redacted]
When received, Nov. 12 1877 Occupation, Laborer
Apparent form of disease, Chr. Mania
Supposed cause of lunacy, Blow on head
Civil condition, Married Discharged,
Condition when discharged,
Died, May 21 1878 Cause of death, Effusion & Softening of Brain
Eloped,
REMARKS: 9 mos. Sym 1st in Duration
Correspond with

Illustration 2: LPH register (1866-1887), c. 1877. Digital redactions by author/Image: LPH Archives.

The registers were the only type of official records retained to account for patients in the first era of LPH's history. Individual case files were not in widespread use in the U.S. until the turn of the 20th century. The social history professor Henry A., who has used historical medical registers from St. Elizabeths in Washington, D.C., for his research, notes to me that at St. Elizabeths it was common practice for physicians to create retrospectively case files for patients who were admitted in the 19th century and were still institutionalized at the turn of the century.[43] In the LPH register, each patient had fifteen lines, so language had to be concise. I observed that the person who initially wrote the early entries had neat, highly legible handwriting, while the follow-up notes after patients died may have been in a different hand and tended to be more rushed and difficult to read. The official categories are registration number, name, sex, age, residence, when received, occupation, apparent form of disease, supposed cause of lunacy, civil condition [marriage status], discharged, condition when discharged, died, cause of death, eloped [escaped], remarks, and correspondence.

The use of the words "apparent" and "supposed" in the categories regarding diagnoses is especially telling of the openly accepted limitation of psychology and the uncertainty of mental health diagnoses in this time period. Such ambiguity in the official categories would disappear in subsequent registers. The handwritten answers also convey professional doubt, as seen in the cause of death category when the causes were written in quotations, e.g., "Consumption," "Heart disease." It is unknown if those quotations were written at the same time the causes of death were recorded or in later years by a skeptical physician reflecting on antiquated diagnoses. Henry A. expresses the challenges of finding patterns in diagnoses and etiologies in these early registers because of the lack of consistency in disease classification. He says, "The recording of the supposed cause of

[43] While I use the real names of other historians in this dissertation, Henry A. is a pseudonym that I created in order to comply with my IRB protocol, which states that I will provide pseudonyms to all interview participants.

the disease was very sporadic. It was really difficult to get any kind of consistency, or consistent documentation of that, in the register book itself."

This first LPH patient register illustrates the creativity that the record creators at the hospital employed in order to ensure that the register continued to serve its purpose, even as that purpose changed over time. For example, during the 1870-1885 time period, impromptu alterations to the register indicate that it was critical that patients were entered into the registers in the order that they were admitted. Clerical errors led to patients being entered in the wrong order, which was rectified by inserting an entry between two official ones. In these instances, patients were given improvised registration numbers, such as "No 1453½." Furthermore, there is evidence that the register increasingly did not provide adequate space for the LPH physicians to track patients throughout their time at the hospital. By the end of the 19th century, LPH faced an increase of long-term, ageing patients that they needed to account for. We also know that U.S. psychiatric facilities were becoming progressively more involved in etiological research of their own patient populations. Some attempts were made to add updates regarding patients' conditions in the register.

In the first LPH register, it is highly unusual to see in-depth information regarding the patients' diagnosed disease or cause of lunacy. Case histories were simply not possible given the space provided. It appears that recordkeeping efforts were made to describe a patient's affliction only if it was particularly interesting and of potential medical interest. In one case of a male patient who was admitted in 1880, his mental health was not described until 1896 by the LPH superintendent, which was many years after the patient's death. This post-mortem entry indicates that the information was recorded not for treatment of the patient but as a record of a peculiar case that was worthy of being remembered for posterity and future study:

> Has delusions of grandeur, wonderful visions etc. Said that he frequently went to hell during the night & returned before morning. Played on the invisible violin, said he got his musical inspiration & songs from hell. At

> times he became violent because he thought he was being persecuted by the authorities whom he said were in league with the devil.

The superintendent's sentences are incomplete, yet very descriptive. Adjectives such as "invisible" and "wonderful" are more evocative and lyrical than clinical. The use of "wonderful" is especially period-specific and refers to the man's visions causing him astonishment and agitation. While such a lengthy description of a patient's affliction is unusual, the record creator was able to do so by utilizing the remarks and correspondence sections.

Not all of the official categories in the register were maintained, and the unused record spaces were occasionally repurposed. All patients who were residing in LPH in 1902 had their statuses updated in the registers; the otherwise unused correspondence section that was part of each patient entry space was used for this purpose. To illustrate, Patient 132 was admitted to the hospital at the age of 25 in 1870 as an "imbecile." Allegedly, his mental deficiency was caused by a blow to the head as child. In his 1902 update, it is said of the now 57-year-old man, "Physical health fair. Totally blind, has come on gradually. Mentally no material change. Dementia." The only register update for this individual comes more than three decades after his admission, and the information about his physical and mental health is extremely brief. Individual case files would become the norm for hospital recordkeeping in the early 20th century in order to improve health care and to have a written record of the medical and administrative decisions made for each patient. The LPH patient admission registers in bound book form with handwritten entries, however, continued well into the 1990s as a means for the hospital to track incoming patients and their legal statuses.

The second register I included in my dataset covered 1871 to 1933. While the first and second register have overlapping years for the first era, I examined the latter only for the entries from the second era, 1925-1940. This register utilizes a different format from the first register. Rather than listing each category for every patient entry, the register has the categories running across the top of the two facing pages in columns, and the patients

are listed in rows. Based on my conversation with Henry A., this style of register was commonly used by mental institutions in the 19th and early 20th century. Henry A. alludes to the limitations of what kinds of information and how much could be entered into this style of register when he discusses "what the register book *allowed* for the clerk to enter." The LPH register has 32 entries per page, which means more information in a smaller space. The smaller spaces for information also means less room for elaboration and individualization for each patient's entry. Besides the difference in the amount of space provided for each patient, the other main format difference is the number and detail of categories; it has twice as many categories as the first register that I examined. The categories are number for year, register number, previous register number, name, sex, admitted, number admissions, number attacks, age when admitted, age psychosis began, marital condition, number children if female, nativity, color, discharged, condition when discharged, died, cause of death, psychosis, committed as feeble-minded, epileptic, duration present attack, whole duration psychosis, where committed, environment – urban or rural, occupation, war service, education, economic condition – how supported, etc., use of alcohol, use of drugs, paralytic/crippled/deformed, blind/deaf/dumb, and heredity.

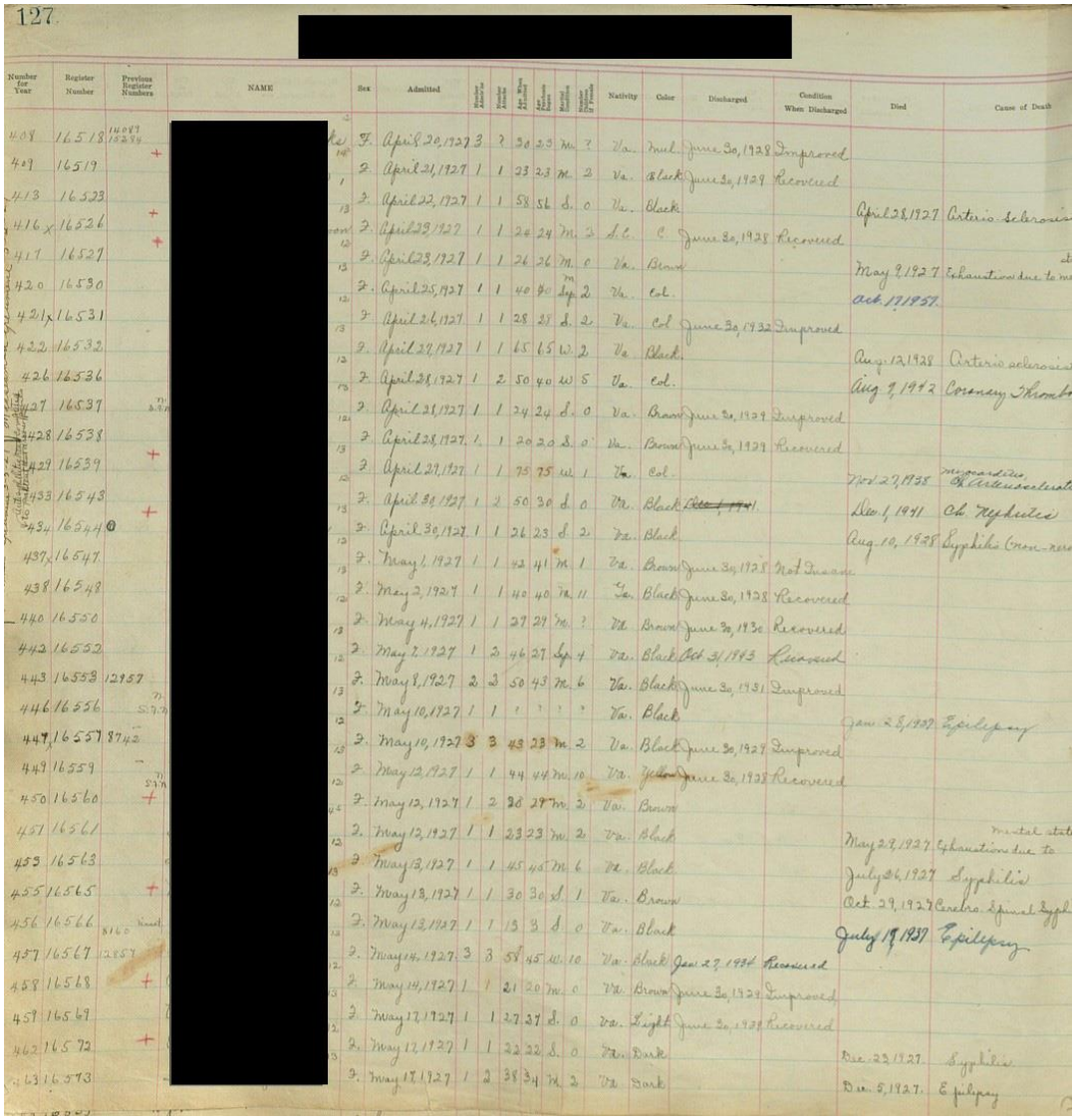


Illustration 3: LPH register (1871-1933), c. 1927. Note: only verso page shown, but patients' information spanned both pages. Digital redactions by author/Image: LPH Archives.

The highly specific categories and the narrow columns and rows of the register allowed only brief responses, numerical entries, or checkmarks. The purchase and use of this more regimented register format suggests that the LPH administration sought to make the registers a site for data collection. By placing information about patients in rows rather than individual boxes, the register is both space-saving and amenable to summation with

ease. For example, the "number for year" category provided the hospital with the population census that could demonstrate to the state legislature the need for increased funding. The patient population grew every year during this time period, reaching nearly 1,000 patients by 1940. With the steady increase in patients arriving at the hospital since its inception, there may have been more than one person entering information into the registers; the variation in handwriting and writing implements suggests so.

The second register's format allows for consistency even if multiple individuals are handling patients' admissions. The register's formatting also places greater textual restraint on the LPH staff who maintained the registers. Compared to the first register, the second register gives the record creators less power to use their own vocabulary to describe their observations of incoming patients. The proliferation of simplified response boxes reduce the recorder's responsibility to remember what medical and administrative categories need to be included. I speculate that the physicians were no longer the primary staff members who met patients upon their arrival and maintained the intake records. The staffing power structure is implicitly maintained in part through the format of the records. As Berg and Bowker (1997) note, "[H]ierarchy is evident in the way just how much of a form is prestructured" (p. 527). The less structured a form is, they argue, the more freedom and control the record creator has over the creation of the narrative, and is reflective of the creator's stature in the hospital environment. The rigid category-focused structure of the register for the 1925-1940 period suggests that lower ranked staff probably maintained the registers and illustrates the "classificatory impulse" (Dandeker, 1990, p. 147) that was becoming popular in the psychiatric discipline.

The formal and informal register categories and written responses in the register demonstrate a rise in the professionalization of psychiatry during the 1925-1940 era. The register illustrates an increase in the adoption of the practices and language of the general medical field, which supports the idea that psychiatrists were attempting to legitimize their work by integrating the etiologies of bodily ailments into their primary focus on problems of the brain. The register shows the superintendent and his hospital staff

making a concerted effort to develop mental illness pathologies by placing the patient and his illness under what I would label as a Foucauldian "gaze." At that time, distinctions were being made between mental illness and mental disability, and within types of diseases. Manic depression could now be manic, depressive, mixed, or hyper manic. Dementia praecox could be hebephrenic or catatonic. The descriptions for causes of death have also become more detailed, indicating greater external pressure to perform autopsies and find the bodily source of harm. One patient is said to have died from an abscess of sub-axillary glands and edema of glottis, while another is said to have suffered from mitral insufficiency and arteriosclerosis. In addition, the registers represent a more formalized interest in the environments that the patients came from, e.g., rural/urban, war service, drug/alcohol use, economic status. There are now information categories about number of attacks (i.e., manifestations of illness) and duration of attacks. Insanity is now called "psychosis." Hereditary information is now its own category. For example, one patient is noted as having an inebriate father, a feeble-minded aunt, and a paralyzed mother.

The second register does not have any additional space for the creation of informal categories. However, in addition to the formal categories, one type of marginalia is seen consistently in 1925-1940. By this era, the LPH register indicates that the hospital was testing patients for syphilis. At the time, syphilis was a generally misunderstood illness that represented a collection of many diseases. It did not have its own formal category, but became an increasing concern for LPH. The register marginalia shows that by 1925, tests such as the Wassermann were being conducted and cerebral syphilis was a common diagnosis. The register, which began in the 19th century, does not have a formal space set aside for results from the Wassermann test, and the record creators made their own informal space by noting results in the upper right corner of the name category or in the previous register numbers category (see Illustration 4). Examples of test results are "pos 4+," "S.F. neg/+," and "-." At this time, patients were still segregated in the records by male and female. For the male patients, there is marginalia noting if they had been

vaccinated, presumably for syphilis. By the early 1930s, LPH was conducting the Bordet-Wassermann reaction, an antibody test. Results were shown as marginalia, e.g., "B+/SFN," "BN/SFN," "SFN/1+." The marginalia for syphilis testing demonstrates how the staff who maintained the registers had to improvise in their recordkeeping practices in order to accommodate medical changes.

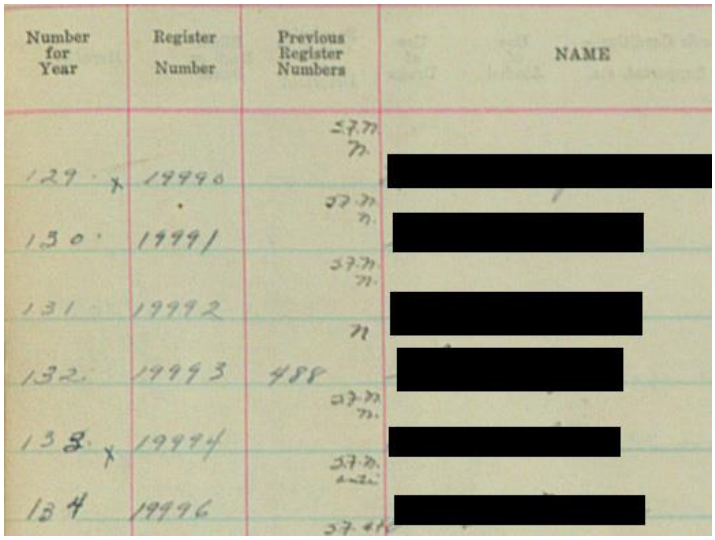


Illustration 4: Detail of syphilis test results in LPH register (1871-1933), c. 1932. Digital redactions by author/Image: LPH Archives.

The LPH staff had to make further decisions on how to adjust the register when its preprinted format could not meet the needs of the hospital. Similar to the register from the first era, the second register had categories that were used to various degrees, depending on the workplace needs at the time. In the late 1920s, a number of the categories were only infrequently used, such as "committed as feeble-minded," "epileptic," "use of alcohol," "use of drugs," "blind," and "paralytic." In comparison to those categories, the "hereditary" category was filled in more frequently. For a seven-month period in 1938, the right-facing pages of the registers were no longer a continuation of information for patients but rather a separate page of entries. I speculate that the hospital register keepers may have realized that they were running out of space

and did not have a new register book on hand, so they made an impromptu reconfiguration of the register by relabeling the columns on both the left- and right-facing pages to mirror each other. Thus, the environment and occupation column became "where committed," the war service column became "Wassermann," and so forth. In having to do this rearranging of columns and categories, the record creators were obliquely acknowledging that some categories were less useful for their contemporary administrative purposes.

I examined five separate registers for the third era, 1955 to 1970; the increase in number of registers reflects the greater number of patients admitted in this fifteen-year period compared to the earlier eras. The first register covers 1954 to 1956. Its categories start with an unlabeled column that was used to count the number of patients each year, followed by register number, name of patient, legal residence, date commission held, date admitted, type of admission, age, sex, marital status, legal status, committed as, and changes in legal status. The entire right-facing page has columns that were intentionally left blank by the register printers. One column left unlabeled was used to note previous registration numbers and veteran status, the latter of which was used frequently during this time period since the hospital was receiving a steady stream of veterans from World War I, World War II, and the Korean War. For the first time, in 1962, a woman is listed as a veteran. Two columns were hand labeled as "Died" and "Dis. [Discharged]," and two unlabeled columns were used for diagnoses. The former categories disappeared by December 1959. The latter category was used for only seven months in 1955, and then diagnoses were no longer included in the registers. The types of mental illness labels that I did see reflect the psychiatric diagnostic trends of the time period. Afflictions such as Manic Depression Reaction and Sociopathic Personality Disturbance (Alcoholism) were often further parsed by severity of the syndrome or reaction, e.g., moderate, acute, severe. The disappearance of the died/discharged and diagnoses categories point to the hospital's use of its registers primarily for patients' admissions only, rather than for tracking the entire lengths of hospitalizations.

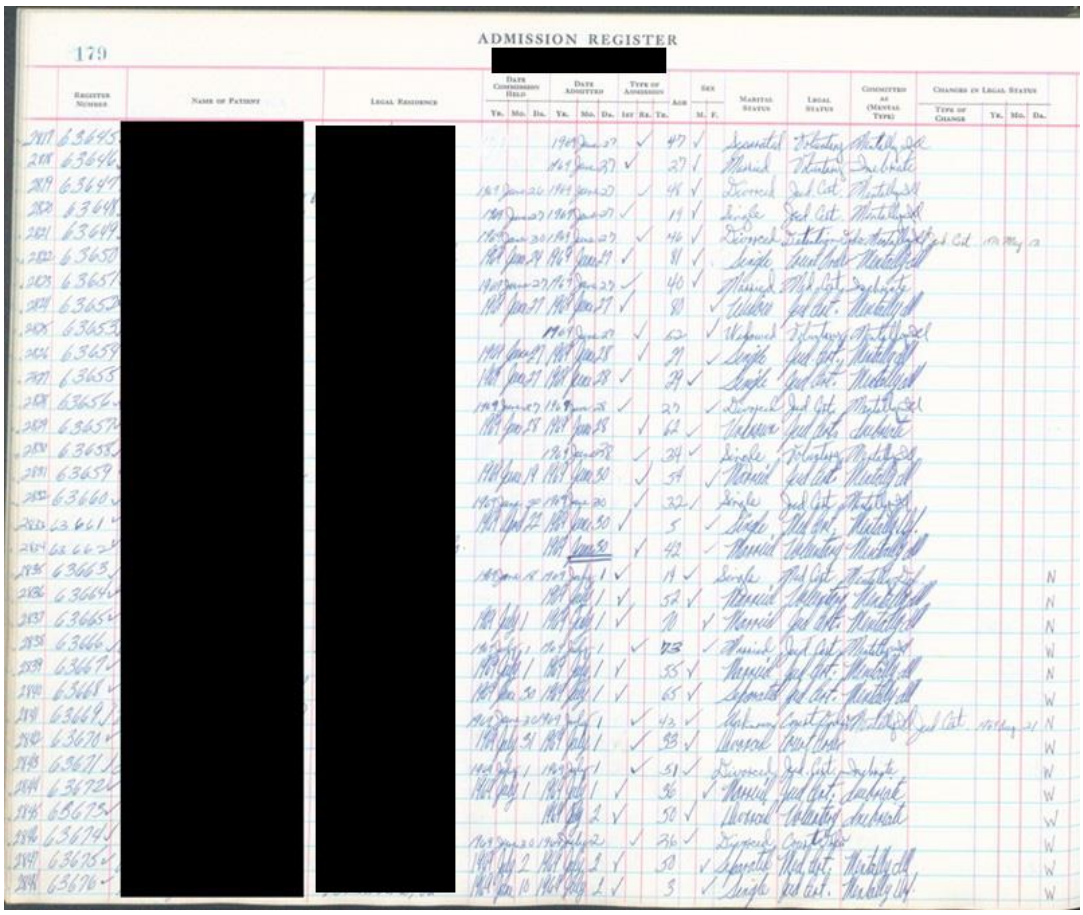


Illustration 5: LPH register (1967-1977), c. 1969. Digital redactions by author/Image: LPH Archives.

The registers also tell us a lot about the tumultuous changes to the patient population at LPH during the third era. The patient population in the late 1960s predominantly consisted of mentally ill adults and mentally deficient children. By the mid-1960s, very few patients over the age of 60 were admitted to LPH, as they were probably considered senile and sent to elderly homes instead. Children were being admitted for mental disabilities, especially in the late 1960s; one child is listed as being admitted at only eighteen-days-old. The emergence of the category of legal status reflects the changing purpose of the registers and, more broadly, the growing inter-organizational relationships between LPH and the court system. Figure 9 illustrates the social world of

the registers during this time, and includes a collective judiciary actor. LPH became a forensic hospital between the latter two eras that I examined, and began accepting patients deemed incompetent to stand trial or be jailed. Answers to the "Legal Status" category were Regular, Court Order, Emergency, Observation, and Voluntary. The second register, 1959-1963, differs from the previous register only with the addition of one new informal category, "Hos. Trans. From," indicating the arrival of patients from out-of-state facilities, including St. Elizabeths in Washington, D.C. I presume these patients were residents of the state where LPH is located and happened to be institutionalized while out of town. In 1967, White patients from other state facilities were transferred to LPH and caused the patient population to explode.

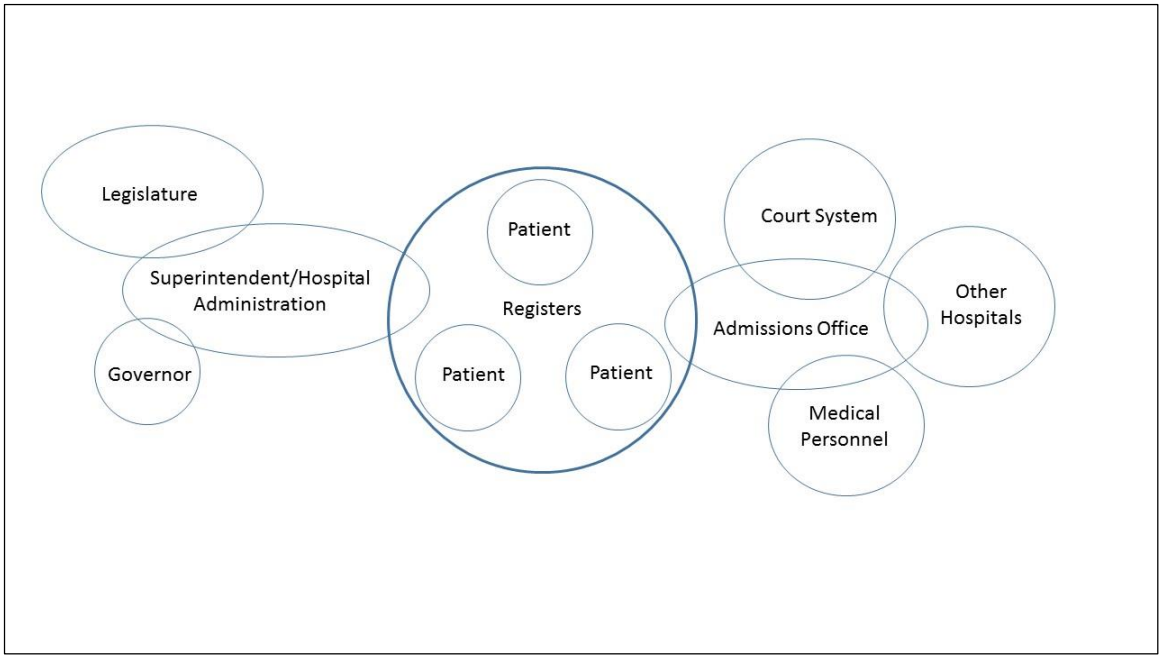


Figure 9: Social world/arenas map of patient admission registers.

The influx of transferred patients in the era of desegregation occurred just prior to the deinstitutionalization at the hospital. The hospital was overcrowded, and the popular national stance on mental treatment was in favor of community-based health care. By the early 1960s, the registers have marginalia that suggests it was becoming increasingly

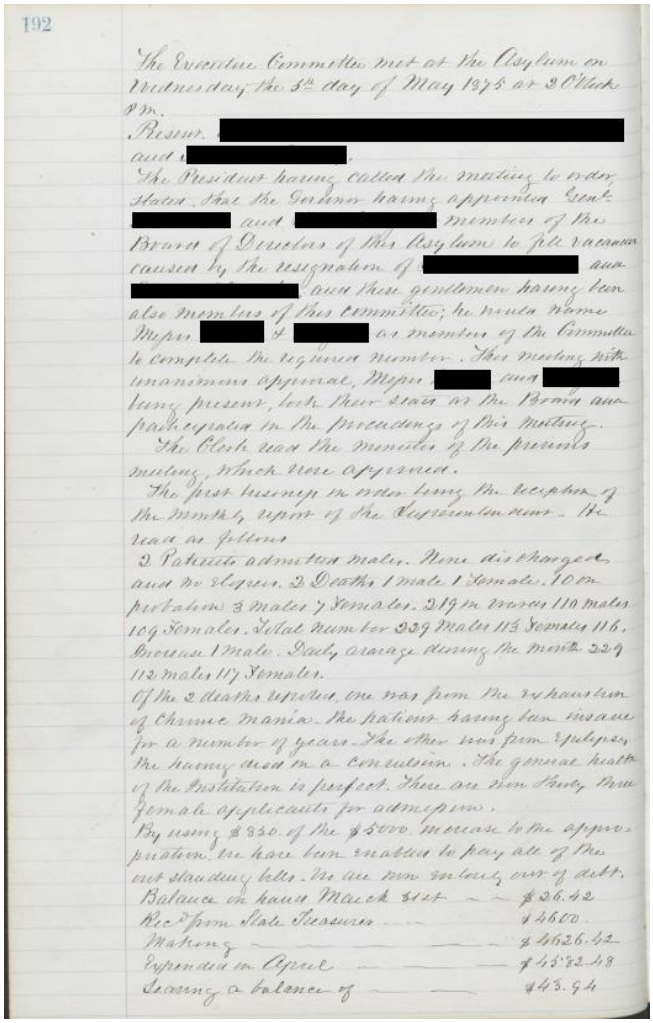
important for the hospital to ensure that their patients were in fact legal residents of the state. LPH was also dealing with relapsed individuals who were sometimes readmitted nine or more times. In the fourth register of the era that covered the years 1967 to 1969, two informal categories appear: "Date scheduled to be staffed" and "Date staffed," which indicated when staff members reviewed the patients' legal statuses and health conditions. And in the last register I examined, 1969-1972, two different informal categories appear: "Presented to Staff" and "Staff Recorded" appear. These categories are evidence of a concerted effort by the LPH administration to discharge or transfer patients out of the overcrowded hospital.

Minutes

Like the LPH registers, the board meeting minutes underwent changes in media and format over time. While the minutes do not have the changing classification headers seen in the registers, I observed longitudinal shifts in the recording implements and record materials used in the minutes. Although the adoption of new recordkeeping technologies allowed for more thorough minute-keeping, the overall organizational structure of the minutes remained remarkably similar throughout the one hundred year period I examined, which speaks to the institutional memory of how board meetings were run and recorded.

Assuming that the 1870-1885 minutes follow the structure of the business conducted at the board meetings, the gatherings of hospital board members and hospital administrative staff followed the same basic format every month. The clerk first noted whether the minutes were for the Board or Executive Committee. Then he provided the date of the meeting, location, and who was present. Next, the minutes inform us that the superintendent gave his monthly report, which was recorded in the minutes as a continuous paragraph of information regarding summations regarding patients (e.g., number of admissions, deaths), "general health of the Institution," financial conditions (e.g., expenditures, monies received, and deficits), livestock and farming updates, etc.

Finally, the Board discussed matters such as the creation of new committees, political negotiations, authorizations to take action, and land purchases, many of which were resolved with resolutions. By the early 1880s, shifts in the Board's membership translated to a slightly different meeting structure with a focus on financial management, especially the examination of bills and any money exchanges such as expenses and deposits. In the minutes, it is noted that the chairman adjourned the meetings, and is followed by the secretary's signature.



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The Executive Committee met at the Asylum on Wednesday the 3d day of May 1875 at 2 O'Clock P.M.

Present [redacted] and [redacted]

The President having called the meeting to order stated that the Governor having appointed Genl [redacted] and [redacted] members of the Board of Directors of this Asylum to fill vacancies caused by the resignation of [redacted] and [redacted] and these gentlemen having been also members of this Committee, he would Name Mssrs [redacted] & [redacted] as members of the Committee to complete the required number. This meeting with unanimous approval, Mssrs [redacted] and [redacted] being present, took their seats at the Board and participated in the proceedings of this Meeting.

The Clerk read the Minutes of the previous meeting, which were approved.

The first business in order being the reception of the Monthly report of the Superintendent. He read as follows

2 Patients admitted males. None discharged and no elopes. 2 Deaths 1 male 1 female. 10 on probation 3 males 7 females. 219 in house 110 males 109 females. Total number 339 Males 113 Females 116. Increase 1 Male. Daily average during the month 229 112 males 117 females.

Of the 2 deaths reported, one was from the exhaustion of Chronic mania. The patient having been insane for a number of years. The other was from epilepsy. The latter died in a convulsion. The general health of the Institution is perfect. There are now thirty three female applicants for admission.

By using $330 of the $5000 increase in the appropriation we have been enabled to pay all of the out standing bills. We are now entirely out of debt.

Balance on hand March 31st	$26.42
Rec'd from State Treasurer	$4600.
Making	$4626.42
Expended in April	$4582.48
Leaving a balance of	$43.94

Illustration 6: LPH board minutes (1870-1884), 1875. Digital redactions by author/Image: LPH Archives.

The parallels in how LPH administrators have overseen the operations of the hospital continues to this day. Dennis H. notes the similarities between the events described in the 19th-century monthly board minutes and his own daily meetings with staff:

> There's some books where the by-laws of the hospital describe what the Superintendent will do, and what the senior physician will [do], and what the Matron will do. […] It looks like what I do and that's from 1890. That you will come in the morning, and the Matron will give your report and then somebody will bring in a report about how many cows and how many food – so basically, I come in in the morning, and a group of people will give me some reports about what's happened over the last day. And we'll try to listen for risk and danger, and try to take care of that as quickly as we can.[44]

The board meeting minutes across the three eras that I examined share what Dennis H. described – accounts of events that pose "risk and danger" and how the Board and superintendent managed the situations. The differences in the accounts across the eras are based in part on the record keeper or keepers at the time, but also on a host of other actors and actants within the record ecologies, such as the available recordkeeping technologies and the intended recipients of the minutes.

From 1870 to 1885, LPH maintained minutes for its monthly Executive Committee meetings and annual Board of Directors meetings in blank books produced by a local bookbinder. Compared to the patient admission registers, the formatting for the minutes is not as restrictive – the lack of preprinted categories and boxes allowed the Board's clerk, to write as much as he wanted for each meeting. Somewhat similar to the period-specific classificatory language and medical jargon seen in the registers, the clerk was constrained, however, by the Board's expectations for how the meeting minutes

[44] The Matron was a female employee who oversaw the care of the female patients, as well as managed the kitchen, laundry, and housekeeping. The position was one of the original hospital employee roles described in the minutes from LPH's first regular hospital board meeting in 1870. Mentions of an LPH Matron disappeared from the records by the late 1920s. While nurses were hired occasionally at LPH during the 19th century, they were hired with greater frequency by the second era; LPH had 126 nurses in 1926.

should appear, i.e., societal norms for institutional board minutes. The early minutes are marked by very legible handwriting, formal language, and edited descriptions of what occurred at the meetings. In regard to the last characteristic, I know that what was discussed by the Board is not always reflected in the minutes, which tended to show only final decisions. From 1870 to 1885, written notifications and statements are copied verbatim into the minutes but oral reports from the LPH superintendent and farmer are only noted as happening and heavily summarized. Board discussions regarding unusual incidents or business are summarized in the minutes. Evidence suggests that the minutes were collectively edited so that the final results were Board-approved accounts of events and decisions. Members of the Board and the superintendent could request amendments to the final record. In a December 1870 entry, the clerk wrote,

> The Clerk was also directed to write out a full report of the proceedings of the last meeting of the Board of Directors to be read to the next meeting of the Committee for the purpose of revision, alteration & addition as necessary, before it was spread upon the record.

The phrase "spread upon the record" is a figurative parliamentary idiom that had seeped beyond the legal world (Garner, 1995), and is seen in the LPH minutes through the 1930s before it fell out of favor. In the hospital board context, the recordkeeping action suggests the creation of a final, public version of recorded events.

In addition to the minutes not standing as an accurate or unedited account of the discussions and decisions that occurred in the LPH board meetings because they were sanitized first by the Board, the records were removed temporally from the imminent external social pressures faced by the Board.[45] Since the minutes of board meetings were always written retrospectively by the clerk, any disruptive events leading up to changes in the board membership or its structure were not recorded. For example, when there were

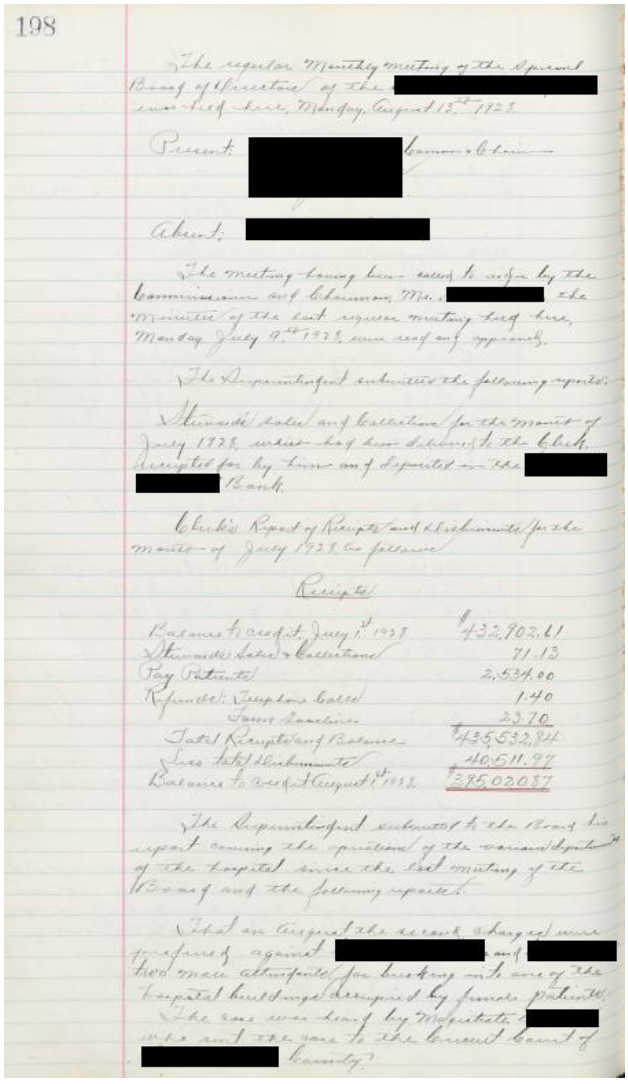
[45] The distancing of events occurring beyond the hospital walls and what was being recorded in the minutes is evident in the mid-1960s minutes, which make only one direct reference to the Civil Rights Act of 1964 despite the Act having been a significant external influence on the patients and hospital environment.

underlying political tensions from the state government regarding the Board and its vision, such controversies were not portrayed in the official minutes until after the entire Board membership had been replaced. I observed a relationship between disruptions in the hospital board organization and subsequent changes in the board's recordkeeping practices. For example, at the start of September 1873, an incomplete report from the Executive Committee is in the minutes. Then, minutes from a Board of Directors meeting later in the month note that a new hospital board had been appointed by the state governor. There is also marginalia, written in pencil, that emphasizes this is a "New Board." No explanation is given in the minutes for the changeover.

In March 1882, yet another overturn of the Board occurred due to a bill passed by the state's General Assembly. With the advent of a new Board, a clerk with a formal hand and a fondness for Latin terms such as "pro tem" and "sin die" began recording the minutes. With every shift in board membership, an evaluation was made of the previous recordkeeping system, and the new Board's decisions regarding the practices of the old Board are in the minutes. In this case, the Board decided the previous practices were sufficient: "On motion of Col [redacted] the present system of [inserted: Book-Keeping] be continued ~~with the exception that the amount above be written in words and figures~~." These examples show us that individual acts of recordkeeping were bounded by the conventions and rules, or system, imposed by the hospital administration and Board, who were themselves influenced by the social expectations of the larger psychiatric communities and record requirements of the state.

The 1925-1940 minutes are characterized by events and discussions that indicate an increase in the hospital's inter-organizational interactions with other state mental hospitals, as well as local businesses, national professional groups, and political bodies. The Board's emphasis on demonstrating fiscal responsibility through good recordkeeping practices is particularly evident starting in this era. The minutes continue to be written in longhand in blank books printed locally for LPH. The Board was called the Special Board of Directors of LPH, and was led by a man who was both the Commissioner and

the Chair of the Board. The monthly meetings began with the approval of receipts. Then the Superintendent orally presented his written report on the condition of each hospital department. The report itself is not in the minutes – and no Superintendent reports appear to have survived – so summations about the patients are absent, but each board member received a copy of the report. Finally, the Board discussed any matters at hand such as construction, financial disputes, and recommendations for hospital improvements.



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The regular Monthly meeting of the [redacted] Board of Directors of the [redacted] was held here, Monday, August 13th 1928.

Present: [redacted] Chairman & Clerk

Absent: [redacted]

The meeting being here called to order by the Commissioner and Chairman Mr. [redacted] the Minutes of the last regular meeting held here, Monday July 9th 1928 were read and approved.

The Superintendent submitted the following reports:

Stewards Sales and Collections for the Month of July 1928, which had been delivered to the Clerk. Receipts for by same and deposited in the [redacted] Bank.

Clerk's Report of Receipts and Disbursements for the Month of July 1928, as follows:

Receipts

Balance to credit July 1st 1928	$32,707.61
Steward's Sales & Collections	71.13
Pay Patients	2,534.00
Refunded: Telephone Calls	1.40
Taxes Canceled	23.70
Total Receipts and Balance	$35,532.84
Less Total Disbursements	10,511.97
Balance to credit August 1st 1928	$25,020.87

The Superintendent submitted to the Board his report covering the conditions of the various departments of the hospital since the last meeting of the Board and the following matters:

That on August the second a charge of murder preferred against [redacted] and [redacted] two male attendants for beating with one of the hospital buildings occupied by female patients. The case was heard by Magistrate [redacted] who sent the case to the Circuit Court of [redacted] County.

Illustration 7: LPH board minutes (1923-1937), 1928. Digital redactions by author/Image: LPH Archives.

The evolving relationships between collective actors affected how LPH conducted its daily business, including its recordkeeping practices. In my analysis, I came across several instances of the Board and the Superintendent discussing changes to the hospital's recordkeeping practices due to other organizations imposing new and often more thorough recordkeeping requirements. The state's General Assembly in 1926 required the hospital to keep a registration record of all personnel absent from work "whether on official or personal business." In 1930, in order to comply with a new requirement from the American College of Surgeons, the Superintendent had unspecified additional medical records printed to be used in the Medical Center Building. Then in 1934, "The Superintendent presented correspondence from Mr. [redacted], Commissioner of Public Welfare, enclosing revised form of commitment papers for the insane, as suggested by Dr. [redacted], Superintendent of [redacted] Hospital." No immediate action was taken, and the Board decided to discuss the matter later. There is no record in the minutes what the Board concluded, and an examination of the commitment papers (which are located in the state archives) would be required to determine if the forms were altered to resemble the ones from the other state facility. In 1958, the Board approved changes to the patient commitment form in order to reflect recent legislation dealing with court-appointed attorneys and returning warrants to the issuing court.

With the change from individual boards for each mental facility in the state to a single state-level board, there is a lacuna in the minutes from 1937 to 1943. When the board meeting minutes return, the only ones that appear to exist are for the State Board. Figure 10 illustrates the social world of the State Board minutes, which included the superintendents from all of the mental institutions in the state, as well as the board members and the state's central office that oversaw the hospitals. For the third and last era, 1955-1970, the meeting minutes are typed on loose-leaf paper, and the minutes in the LPH collection are photocopies. Before I processed the LPH collection and applied preservation measures to the records, each month's minutes were bound by a metal

staple. The order in which business was discussed at the State Board meetings for this period was always the same: unfinished business followed by each state facility reporting its monthly news, then general business (e.g., lists of voluntary patients and sterilizations, applicant numbers, personnel "additions and separations"), and new business. Each month's minutes ends by noting that the meeting went into executive session, the proceedings of which were not recorded in these minutes. Date stamps on the archival minutes from this era tell us that LPH received a copy of the minutes several weeks after the meeting took place. The State Board minutes from the mid-1960s in the LPH archives are marked in ink, indicating that someone from the hospital was keeping track of the LPH-specific matters in the minutes.

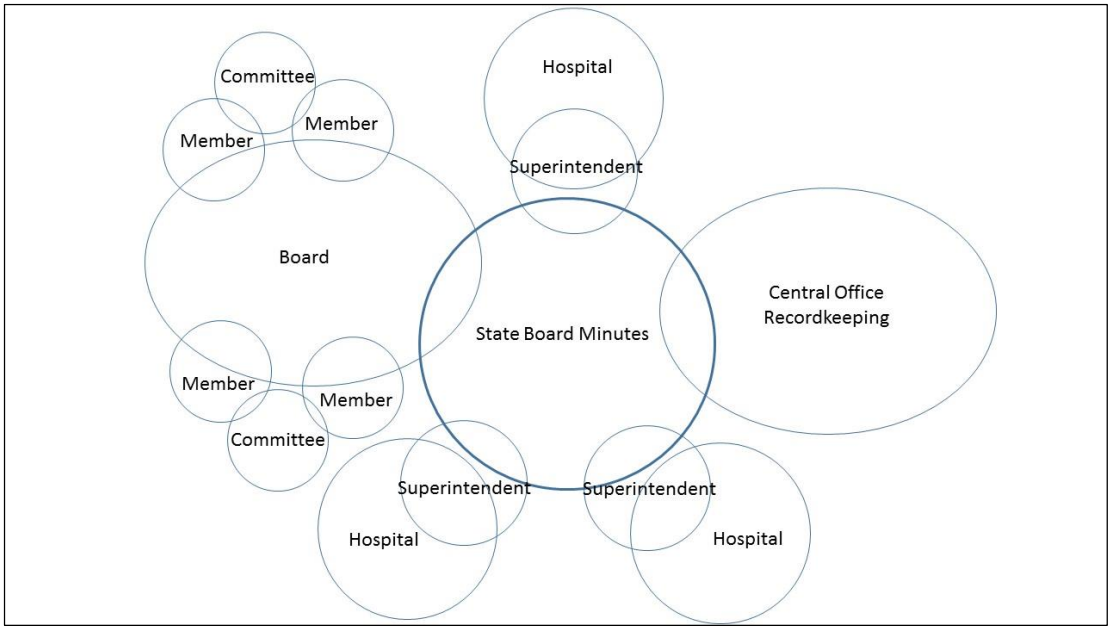
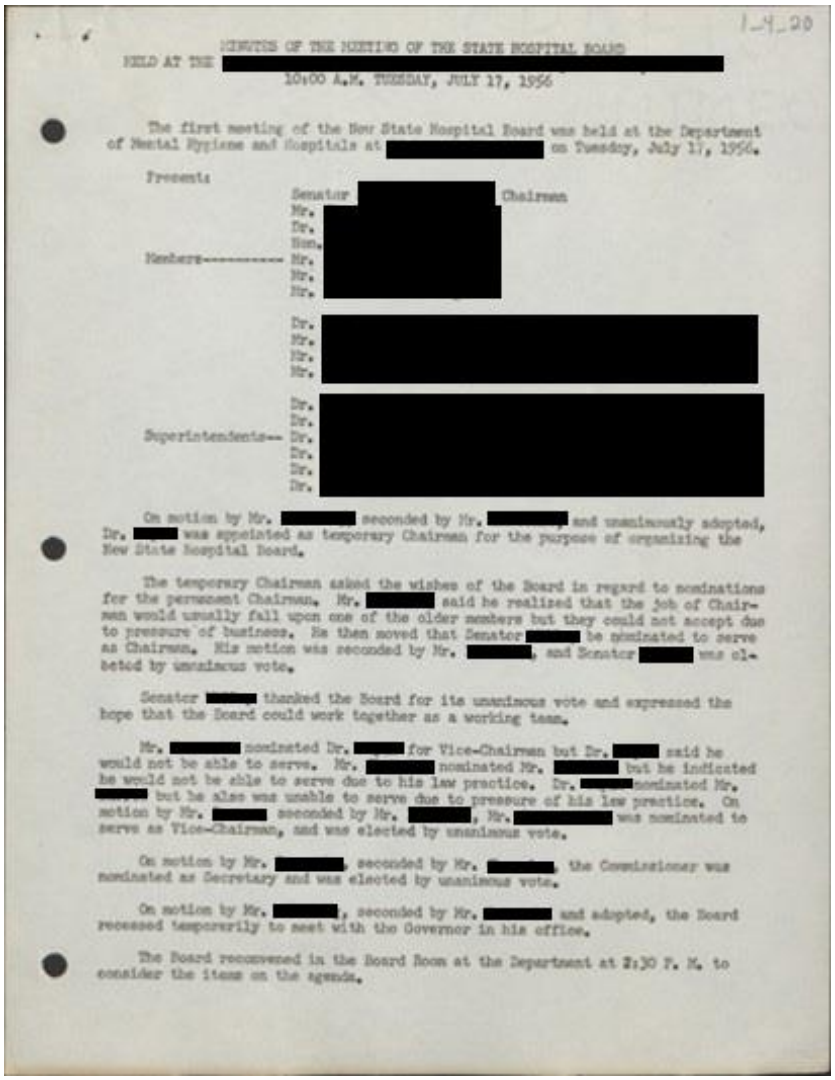


Figure 10: Social world/arenas map of State Board minutes.



1-4-20

MINUTES OF THE MEETING OF THE STATE HOSPITAL BOARD
HELD AT THE [redacted]
10:00 A.M. TUESDAY, JULY 17, 1956

The first meeting of the New State Hospital Board was held at the Department of Mental Hygiene and Hospitals at [redacted] on Tuesday, July 17, 1956.

Present:

Members---------- Senator [redacted] Chairman
Mr.
Dr.
Hon.
Mr.
Mr.
Mr.
Dr.
Mr.
Mr.
Mr.

Superintendents-- Dr.
Dr.
Dr.
Dr.
Dr.
Dr.

On motion by Mr. [redacted] seconded by Mr. [redacted] and unanimously adopted, Dr. [redacted] was appointed as temporary Chairman for the purpose of organizing the New State Hospital Board.

The temporary Chairman asked the wishes of the Board in regard to nominations for the permanent Chairman. Mr. [redacted] said he realized that the job of Chairman would usually fall upon one of the older members but they could not accept due to pressure of business. He then moved that Senator [redacted] be nominated to serve as Chairman. His motion was seconded by Mr. [redacted], and Senator [redacted] was elected by unanimous vote.

Senator [redacted] thanked the Board for its unanimous vote and expressed the hope that the Board could work together as a working team.

Mr. [redacted] nominated Dr. [redacted] for Vice-Chairman but Dr. [redacted] said he would not be able to serve. Mr. [redacted] nominated Mr. [redacted] but he indicated he would not be able to serve due to his law practice. Dr. [redacted] nominated Mr. [redacted] but he also was unable to serve due to pressure of his law practice. On motion by Mr. [redacted] seconded by Mr. [redacted], Mr. [redacted] was nominated to serve as Vice-Chairman, and was elected by unanimous vote.

On motion by Mr. [redacted], seconded by Mr. [redacted], the Commissioner was nominated as Secretary and was elected by unanimous vote.

On motion by Mr. [redacted], seconded by Mr. [redacted] and adopted, the Board recessed temporarily to meet with the Governor in his office.

The Board reconvened in the Board Room at the Department at 2:30 P. M. to consider the items on the agenda.

Illustration 8: State Board minutes, 1956. Digital redactions by author/Image: LPH Archives.

The Commissioner/Chairman of the Board experimented with the format of the minutes in this last era. The July 1957 minutes are noticeably shorter at five pages than the minutes of previous months. Besides not listing voluntary or sterilized patients, the minutes do not include details of the Board's discussions. At the next meeting, the shorter length is explained – it was an intentional decision by the Chairman and carried out by a

secretary. The board members, however, express their desire to have more information in the minutes rather than less:

> The Chairman told the Board he had talked with Mrs. [redacted] about summarizing the minutes so they would include the action but not the details, and the minutes for the July meeting had been prepared on that basis for distribution to the Board Members. He explained that she had also prepared the full and detailed minutes and had them on file in case the members of the Board wanted to know any of the details. He asked for the wishes of the Board as to the type of minutes they preferred. The members of the Board unanimously expressed the feeling that they would rather have the detailed minutes, and it was decided that the detailed minutes should continue to be distributed to the Board Members.

The Chairman's intentions for changing how the minutes were prepared and distributed are unclear, but I speculate that he wanted to minimize the amount of paper distributed to the board members, perhaps thinking they did not want to read and retain unnecessarily long reports. However, his orders to condense the minutes for the board members were soundly rejected; the members wanted to have on hand detailed summaries of their meetings. Rather than being a record type that was administratively required but not practical for collaborative work, the comprehensive minutes were actants that served multiple purposes across overlapping social worlds. The minutes were at once required administrative paperwork, a device for recall, and tool to move committee work forward.

Ironically, the July 1957 minutes do not reveal why the Board preferred the longer minutes, but it may be because its members would rather have their own copies than to request them from the State Board's archives. The ability for the board members to easily have their own copies of the minutes was possible only with the photocopying technology that the hospital had in this era. On the other hand, the material resources and staffing required to distribute copies of the minutes were still greater in 1957 than it is today, in which a word-processed document can be sent over electronic mail. Three years later, the minutes are once again shorter and less detailed. The disagreement among the board members regarding the length of reports continued; in July 1961, the minutes note a discussion regarding the length of the monthly statistical reports and whether the

reports should remain in their traditional long form or a shorter length with a "recapitulation sheet." The Chairman assured the other board members that the report could be prepared both ways; the ease with which he suggested having two versions prepared of the statistical report in 1961 and of the minutes in 1957 points to the state mental health division's substantial secretarial workforce and his expectations that the secretaries, as the record creators, would meet the record needs of the Board.

The secretaries' summarization efforts are what Strauss (1985) identifies as articulation work, which he posits as the "supra-type" of labor needed to integrate, or "mesh," the tasks performed by other workers (p. 8). While articulation work is necessary to complete an "arc of work" (p. 2) within an institution or among several organizations, the efforts are often unacknowledged by higher administration. Thus, articulation work is also silent work (Star and Strauss, 1999), as evidenced by the state mental health division's female secretaries not recognized for their labor despite producing reports and minutes that were widely seen within the agency and by the board members In contrast, the work by the Director of Division of Mental Hospitals was openly praised in the 1961 minutes: "The Chairman called attention to Mr. [redacted]'s excellent report showing a comparative analysis on Operating Statistics and Costs for the past six years. He said he had received a number of complimentary remarks and letters concerning this report." By 1968, the signed official copy of the board minutes was being filed at the State Hospital Board's office.

Technology

Changes in communicative and recordkeeping technologies have affected how records were created and preserved at LPH. If adopted into everyday recordkeeping practices at the hospital, technologies such as carbon copies, microfilm, typewriters, audio recorders, photocopiers, and electronic mail in turn changed not only how LPH employees created and maintained records, but also what was recorded, who had access to the record, and if and how the record was preserved for posterity. As with the minutes,

the use of audio recordings helped in the creation of reports with word-for-word reconstructions of speeches and conversations that took place at the board meetings in 1955-1970. Meanwhile, the implementation of the typewriter during that period meant that the minutes could no longer be maintained in bound volumes, but rather were produced on loose leaf paper. The photocopier allowed the Chairman to distribute copies of the minutes to all of the board members and maintain a separate official copy for the State Board archives. In addition to the registers and minutes, other types of hospital records and recordkeeping activities at LPH were affected by new record technologies.

Microfilming became prevalent at LPH in the 1950s to address the proliferation of paper-based case files in their medical records departments. At an October 1956 meeting for stewards, who assisted the superintendents in the day-to-day management of the hospitals, the matter was brought up in relation to whether microfilming was part of their job responsibilities:

> The question of microfilming old records at the several hospitals, which appeared on the agenda, was brought up by Mr. [redacted]. He was advised by some of the Stewards that, except for the mechanics of having the microfilming done and providing the money to do it with, they did not have anything to do with the matter of microfilming the patient's records at the hospitals.

The division of labor was clear, according to some of the stewards – they were not responsible for the microfilming, just the "mechanics" and financing. At the time, microfilming appeared to be an especially low priority for LPH, as shown by the continued discussion: "It was brought out that some of the hospitals had not done any microfilming for several years, especially Larch Point Hospital, when the last microfilming was done in 1948. It seemed that [another state hospital] was well up-to-date on its microfilming." The apparent space-saving need for microfilming had reached a point, however, where it could not be ignored, as long as it became a duty for another group: "Mr. [redacted] suggested that the Stewards discuss this matter with the Superintendents and try to work out some kind of schedule for having this work done.

Further than that, Mr. [redacted] did not feel that we should enter into this matter." According to my research, the group that was in charge of preparing the records and microfilming was composed predominantly of women. According to Loretta M., by the time she started working at LPH in the 1970s, it was the hospital clerks that prepared the files to be microfilmed. The clerks at LPH during this period were all female. Furthermore, while the records were microfilmed at several locations outside of the hospital, the one of note is a nearby women's correctional facility.

With the advent of microfilming at LPH by the 1950s to ostensibly create more record storage space and to preserve patients' record information, duplicates from the original case files were thrown out before the microfilming process and the files in their entirety were destroyed afterward. Loretta M., who was a clerk at LPH, managed the transition of records between two environments and purposes in the hospital; she dealt with case files that came from the in-use treatment environment, where medical teams used the charts to assist with patients' care, and the medical record department, where the records were stored once a patient was discharged. The immediate period of time after a patient was discharged was a critical time to ensure that the charts were in order and complete:

> During the time I worked in the Forensic Unit, we kept those records for 45 days after the patient was discharged. I was the person that when a patient was discharged, we'd get that chart the next morning. I would make sure that everything was in order or, you know, put the chart in what we call, um, purging order.

The "purging order" was part of the process to prepare the records to be microfilmed. In terms of the content of the files, Loretta M. ensured all of the required forms were present, checked the dates on the forms, and checked that the proper signatures were in place. If signatures were missing from any of the nurses or doctors, she would have to make sure they signed the forms. Loretta M. also engaged in the physical preparation of the records. She says that during her time at LPH "all of the information – just about – was done in duplicate. When the patient was discharged, we kept the originals, discarded

the duplicates." In addition to destroying duplicates in the now non-active patient file, she was tasked with ensuring the remaining files were in good physical shape to be microfilmed. This in-house activity was a cost-saving measure by the hospital administrators, who wanted to "prepare their own records to send out so then when we send them, they are just ready to be microfilmed." Her duties involved making "sure every sheet was flat."

In order to convert the records from one format to another, Loretta M. was one of many actors and actants who took part in a larger recordkeeping ecology. This ecology includes the patient records and their inherent material characteristics as paper and microfilm, changing technologies, a network of hospitals agreeing to the same reformatting practice, and a recordkeeping environment with space limitations. Loretta M. and her fellow clerks were an integral link in a chain of actions. They were the intermediary actors providing the human labor necessary to make the records amenable to microfilming, a mechanized process involving another interconnected ecology of actors and actants. Loretta M. further explained her everyday interactions with the files and the material quirks of paper records:

> Even the edges if they were like, bent up, if you couldn't straighten them, you'd tape them down because when they went through that machine, you didn't want anything jamming it. So everything had to be flattened and corrected. You always had a system of records that had punch holes in them. Sometimes those holes, you had to tape them down so that sheet runs through, you kept going and all. It takes time.

Loretta M. describes the material characteristics of the paper records, e.g., bent corners and hole punches, that needed to be attended to if the documents are to move successfully through microfilming. For her, record preparation required tactile, repetitive, and fastidious work. The physical appearance of the original patient files very much played a role in Loretta M.'s daily workplace activities. Furthermore, Loretta M.'s recollections demonstrate that records as actants affect hospital personnel not only in what they do and how they do it, but also what the actors remember about their duties.

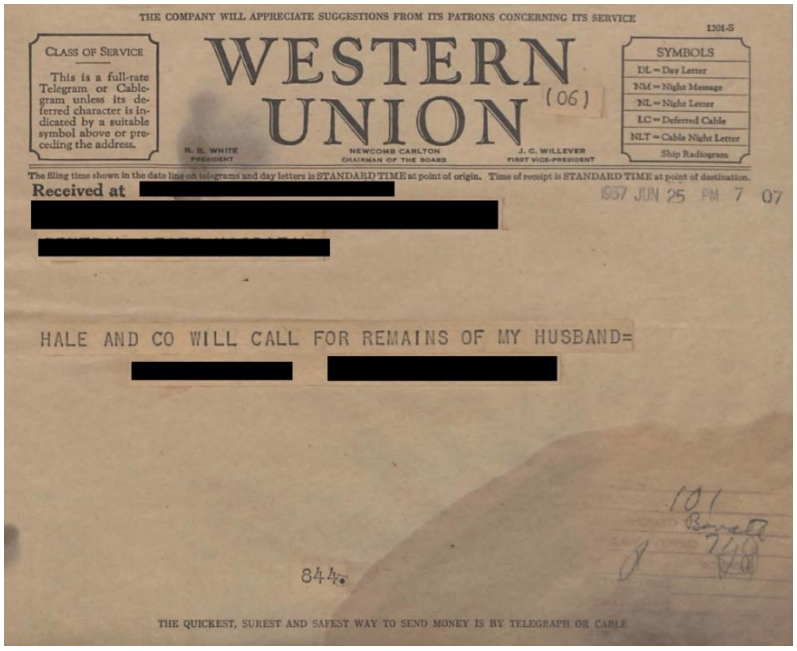
From my interviews with staff members who regularly handled hospital forms, I noticed that the physical characteristics of the documents played a strong role in what they could remember about their record management practices from a decade to several decades ago. While they often could not remember the exact names of the forms or the recordkeeping requirements that prompted the documents' creation, they could recall the color and size of the materials, e.g., pink papers, green registers, and three-inch ring binders. For example, Betty T. specifically recalled the color of the audio tapes that the doctors used to record their notes and were passed on to the clerk stenographers to be transcribed: "We started out with red ones, then they had really pretty blue ones." Loretta M. remembered the paper forms used by the treatment teams:

> You had the physician's notes where the psychiatrist wrote on, and then you had the green forms that the psychologist used, and then you had the recreation/occupational staff, they had their forms that they used. The [blue] ID notes usually all the aides work with them and then some of the staff would write on those, too.

Her easy recollections of the color each form used by different medical personnel suggest that visual (as well as tactile) clues can be useful for repetitive workplace practices, and such material characteristics are lost when the records are converted to another format.

Despite the hospital's good intentions in microfilming patients' records, the format conversion ironically made long-term access to patients' files more difficult for LPH and non-LPH users alike. The processes of microfilming or photocopying patients' files and then burning the originals to destroy them was a common practice in the state's mental hospitals. In the LPH archival collection, I processed sixteen extremely fragile patient files that somehow survived being burned. These files consisted of correspondence between the patients' families and the hospital as well as death notices (see Illustration 9). Their creation dates range from 1926 to 1945. As microfilm, the various forms are no longer different colored sheets but monotone rolls of microfilm. If the LPH information release coordinator wants to find pertinent information about a patient whose records are only on microfilm, he must use the last functioning microfilm

reader available at the hospital in order to scroll through the film. The dependence on a working reader, an obsolescent tool, is not the only access limitation for non-LPH users.


THE COMPANY WILL APPRECIATE SUGGESTIONS FROM ITS PATRONS CONCERNING ITS SERVICE

1201-S

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WESTERN UNION (06)

SYMBOLS

DL = Day Letter
NM = Night Message
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LC = Deferred Cable
NLT = Cable Night Letter
Ship Radiogram

R. B. WHITE, PRESIDENT — NEWCOMB CARLTON, CHAIRMAN OF THE BOARD — J. C. WILLEVER, FIRST VICE-PRESIDENT

The filing time shown in the date line on telegrams and day letters is STANDARD TIME at point of origin. Time of receipt is STANDARD TIME at point of destination.

Received at [redacted]

1937 JUN 25 PM 7 07

[redacted]

HALE AND CO WILL CALL FOR REMAINS OF MY HUSBAND= [redacted]

844

THE QUICKEST, SUREST AND SAFEST WAY TO SEND MONEY IS BY TELEGRAPH OR CABLE

Illustration 9: Telegram to LPH from patient's widow, 1937. Digital redactions by author/Image: LPH Archives.

In conjunction with the current privacy laws for health care record information, the rolls of microfilm are a challenging format for archival access. The archivist, Ann P., who processed the records from several other hospitals in the state, described her discovery of the destruction of original records after they had been photocopied:

> There were Photostats of those records and I thought, well, they must exist somewhere. And then then I saw the memo that basically said their policy was to film it and burn it. That was it. So, you know, that's all we have are those Photostats of a handful of really early, early stuff.

Problematically, the order in which LPH had the patient files microfilmed in conjunction with privacy laws will make archival access challenging. Serialized microform "store images sequentially on a continuous roll of film. *To locate one image, you must pass*

through all the images before it on the roll" (South Carolina Dept. of Archives & History, n.d., p. 5, italics mine). At LPH, a roll of microfilm has black and white document images for multiple patients, and the order is by patient registration number so, while the order of the patient files reflects the order that individuals were admitted to the hospital, the death or discharge dates for patients are not chronological. Patient information that falls under HIPAA is only publicly accessible 75 years after the patient's death. Therefore, unless granular redaction is possible, access to one individual's files and not another's on microfilm is impossible.

Ann P. pointed out that, for the microfilmed patients files she has seen, they can also be organized by date of discharge or death. Therefore, she noted that the records of a patient who had been institutionalized for a lifetime and died at the hospital could be next to the records of a young patient who was discharged after 30 days in the hospital. While the records for the former may be legally open to the public now, the latter's will not be until 75 years after that person's death. Due to the adjacent positions of the records on microfilm, Ann P. acknowledged,

> It's really kind of impossible to serve that sort of information to the public because it's so heavily restricted, it would be impossible for us to redact on that level. So the film is not all that helpful, so I really am sad about that burning thing. It was one of those heartbreaking moments when you're processing that.

The paper-based patient files that were burned by multiple state mental facilities are not the only types of paper-based records that are at risk for obsolescence and possible destruction.

When LPH phased out one recordkeeping technology for another to perform the same or a similar task, the fate of the records created using the former can often be grim or unknown. The Master Index Cards are one example of an obsolete record form. In the medical records department of LPH, there are several large metal filing cabinets packed with approximately 100,000 index cards that are called the Master Index Cards. Each one corresponds to a patient, and they are arranged alphabetically by patients' last names. The

card includes the patient's name, age at time of admission, race, religion, diagnosis, social security number, address, and so forth. For patients who have been readmitted (often multiple times), their follow-up cards with new registration numbers are stapled to their old cards. It is unclear when these cards were created, but it was most likely during the mid-20th century since all of the cards are typed. The Master Index Cards are no longer created, however. During our interview, Dennis H. observed that the cause was probably the advent of an electronic database for basic patient information: "Avatar is invented, and that probably was the end of [the Master Index Cards]. Avatar is the central office's computer system. It's where we put demographics now, and I bet when Avatar was invented, was the last day – '85, '86." Avatar Solutions is a company that provides hospitals and clinicians with an AMA-endorsed suite of health care survey tools.[46] For the hospitals in LPH's state, Avatar represents a centralization of information and control. With the creation of a new system, the Master Index Cards became an outmoded form of recordkeeping, and they are now in preservation limbo, no longer used other than by the hospital's information release coordinator to cross-reference patients' information found in different types of records (e.g., patient registers and case files). While the Master Index Cards and the metal filing cabinets that they reside in are a long-standing fixture of the medical records department, it remains to be seen what will happen to them in the long term.

Digital technologies have affected and will continue to affect the daily recordkeeping practices at LPH and what information is preserved. Robert L. was an administrative staff member for over 25 years and experienced the shift to email as one of the primary form of communication at the hospital. He maintained his own system of recordkeeping in which he kept copies of documents, included printouts of emails, in binders by year in case he needed to recall any of that information. In his reflection on the

[46] http://www.avatarsolutions.com/

eventual phasing out of paper-based communication to electronic, Robert L. noted the ease of using paper in that he can retrieve information more quickly in some ways because of his memory of where a particular document is located and having it literally "on hand." These binders were thrown out after his retirement, which he saw as within the hospital's right to do. For Robert L., paper documents nevertheless are more permanent artifacts than electronic ones. The printing out of documents provides him with a sense of longevity that he is unable to achieve with digital documents. While acknowledging the convenience of email and other electronic surrogates for face-to-face interactions, such as training courses, Robert L. views electronic documents to be much more ephemeral and at risk for loss than paper materials. He said matter-of-factly, "And of course, since we had the computer, a lot of information is no longer in paper form. It's all in email, some of which has disappeared, too." The manner in which he spoke suggests that the impermanence of digital communication and electronic documents is unsurprising to him and an accepted reality at the hospital.

Concerns about what will happen to the electronic records created at LPH and other state facilities emerged spontaneously from a few of the interviews although looking at the long-term management of LPH's digital systems was outside the scope of this study. Changes in technology are greatly affecting modern recordkeeping practices. At LPH, the mandatory switch to electronic health records is to occur in 2015. Throughout the hospital's history, record-making and record-keeping technologies such as typewriters, Photostats, microfiche, and audio tapes affected what information was recorded and how it was distributed. By the late 1960s, I noticed the increasing frequency of audio technologies used in the board meetings: a reporter was granted use of a tape recorder in a meeting, and excerpts transcribed from the tape were said to be attached to the official copy of the minutes. Tape recorders were also used in a meeting in which the hospitals' medical residents brought grievances before the Board. Based on my interviews with former clerks, audio tapes were used by doctors to record information about patients, which clerks later transcribed into patients' case files. Computers are

mentioned for the first and only time in March 1968 when a superintendent of the children's state mental facility noted the possibility of using the technology to score psychological tests at her hospital.

Like all hospitals that are facing the transition to electronic recordkeeping systems, LPH doctors and administrators are now addressing the challenges of learning a new system and adjusting to its limitations to meet their current workplace practices. It appears that the adoption of an electronic records system that works well across health facilities has not yet been achieved. A major reason for the difficulties is that the new system was built by companies outside of this particular medical practitioner community, and therefore unaware of the context-specific needs of these health care providers. As a result, medical professionals are having to improvise ways to communicate and share information. Unlike the paper-based records ecologies that were allowed to develop over many decades, the current electronic records ecology includes many provisional and disparate communication solutions. With the electronic system used by other facilities and the reality of patients moving frequently between facilities, Dennis H. noted the inconvenience and wastefulness of a computer system that is unable to summarize daily notes from nurses, doctors, and labs. Rather than a summary of care for a patient, he receives a large stack of paper: "[T]here's no way of getting at an aliquot of records." He says of the staff members who gather for him the records of transferred patients, "All they can kind of do is copy, copy, copy." Dennis H. expressed concern about the current direction of electronic health care record management: "So communication has gone down as opposed to up. I mean, a big part of electronic health records was this whole data exchange but I haven't seen people doing a very good job."

Materiality and format are actant characteristics that play a part in the changing LPH record ecologies, mediating how information (patient or institutional) is recorded, and affecting the relationships between both individual and collective actors. The materiality of records and documents has been and continues to be important in ensuring the continuity of workplace practices at LPH from day to day. When I spoke with

individuals who created or managed patients' records, I observed that, while the categories on forms and information regarding specific patients are not remembered, the daily, repetitive practice of ordering documents is. The records take up space, whether in the wards or in the Medical Records department. They are the connective element in work flows and physically get moved around the different departments; in doing so, they trace the movement of patients in and out of the hospital, the doctors' work, and work practices such as medical and legal procedures. By existing, the archival records become part of the hospital's institutional reputation, with the potential to affect current race relations, the political standings of the hospital and the state, and ongoing stakeholder relationships among stakeholders.

ACCOUNTABILITY AND POWER THROUGH RECORDS AND RECORD-KEEPING

In the previous section, I focused on the relationship over time between the physical characteristics, formatting, and technological aspects of LPH records and the manner in which iterations of the hospital's staff and Board conducted their everyday business. Next, I turn my attention to the motivations underlying the creation and sharing of records at LPH and its organizational network. Specifically, I examine situations that I believe are portrayed in the records and in the interviews that involve one or more of the three high frequency codes that relate to a record's purpose: accountability, hierarchy/power, and economics. Situations that also fall under a fourth code, inter-organizational dynamics, are especially prevalent in the 20th century eras that I chose to study.

I first look at how and why LPH employees created certain records for what we would now call accountability purposes. Whether the records presents a delineation of duties for hospital positions, financial decisions, or a description of an unusual event involving a patient, the record creator's intent appears to be rooted in wanting to have written evidence of an action or decision that was made. A host of actors, including the

record creator, is involved in ensuring that the hospital, as a collective entity composed of actors from all parts of the institutional hierarchy, is not legally culpable for negligence if disputes arise. The actors who are part of this document-producing ecology drive the quotidian practice of maintaining records for accountability. I then discuss the movements of records and the information that they bring to different actors within different record ecologies, and how the ways in which information moves relate to the maintenance of power in medical environments. Broadly, the horizontal flow of records allows LPH and its sister hospitals to share information in a relatively egalitarian manner and promotes camaraderie, but the uneven vertical flow of information demonstrates how both the restriction of information from the top down and the abundance of records being produced for higher administration serve as a means to control. Finally, I address the ways in which records have served as mediators between hospital staff and patients, especially how records have informed the way in which the former perceived and treated the latter. In addition to discussing case files, I talk about patient-related records that are for administrative purpose and not intended for direct use in patients' care; I argue that these records can have as great an impact, if not more, than patient care records on how the patient is regarded socially both inside and outside the hospital environment. Institutional records and the establishment of daily practices to create and maintain those records are integral to the upholding of hierarchical relationships and bureaucratic environments.

Accountability

Hospital records, as part of the "medico-legal enterprise" (Garfinkel, 1984, p. 198), have been and continue to be participants in the everyday hospital activities at LPH, including patient transfers, admissions, and discharges. Like any medical organization that is part of a larger bureaucracy, LPH demonstrates accountability through its documentation (Olson, 1995; Yakel, 2001b). The word "accountability" (2011) has been part of the English language since 1750, but for this dissertation, I refer to it in the

modern sense that appeared in the late 20th century: the "liability to account for and answer for one's conduct, performance of duties" to the public, funders, etc. This relatively recent usage of accountability has been interpreted in many ways by businesses and organizations, and the multiple assumptions underlying "accountability" has led to miscommunications within and among these actors. The political scientist Jonathan Koppell (2005) attempts to clarify what accountability means in the public sector by first noting the conceptual fuzziness of Chandler and Plano's (1988) broad definition that identifies accountability as "a condition in which individuals who exercise power are constrained by external means and by internal norms." Then Koppell characterizes accountability in the public sector as having five distinct facets: transparency, liability, controllability, responsibility, and responsiveness. "Organizational dysfunction," Koppell argues, occurs when public administrators inadvertently focus on multiple dimensions of accountability (p. 99).

I argue that having many types of accountability expectations at once, for better or for worse, is inevitable in a multi-organizational state government bureaucracy, and records are at once the products and the active mediators of these numerous public sector demands. Based on the data that I analyzed from the LPH records and my interviews, the primary reason for individual or collective actors to create, maintain, and preserve records at the hospital was to provide evidence to superiors for performance evaluations and in legal and financial situations. The minutes, admission registers, and other types of hospital records such as case files and daily logbooks are all actants that participated in sustaining the power relationship between many legal and medical institutions, including LPH.

The 1882 board by-laws included recordkeeping requirements for nearly all of its stakeholders that ranged from daily practices to annual ones. A significant portion of the LPH superintendent's (who was also the primary physician) duties was to create any patient-related records, including the patient registers and daily patient logs. While nurses and clerks took on many daily recordkeeping duties by 1955-1970, no nurses are listed in

the initial 19th-century hospital roster, and the matron had no specified record-creating tasks.[47] The Superintendent had daily duties to record patients' health conditions:

> Every evening, at an hour designated by the Superintendent, both wards shall be examined, the male ward by the Superintendent and the female ward by the Assistant Superintendent and each patient shall be assigned a bed room and the occupant or occupants of all apartments shall be designated by name and entered in the night book which shall be kept as a permanent record.

The nightly logbooks, which appear to have been either destroyed, been lost, or are possibly still somewhere on the hospital grounds, became particularly urgent after a rash of pregnancies in the female ward most likely caused by male attendants in 1872. Ostensibly, the logbooks helped to ensure that the Superintendent was both protecting his female patients and keeping closer watch on his male attendants. Furthermore, if additional patients became pregnant, there would be written evidence of the Superintendent's assiduous ward inspections or lack thereof.

The Superintendent also had to present to the Board a quarterly report that provided a summation of the hospital's activities, as well as anecdotal stories that illustrated the hospital environment:

> A brief statement of its general condition with such suggestions and remarks as he may deem useful. At each annual meeting [inserted: of the Board] he shall present a tabular view of the institution for the year with minute details from the records, and accompany it with a condensed report of other interesting and useful facts and circumstances, experiments and opinions illustrating its management, conditions and prospects.

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[47] I speculate that the early Board did not require recordkeeping by the matron because it recognized that the woman who filled the position would be African American and possibly a newly freed slave; therefore, she would most likely be illiterate. Ransom and Sutch (2001) estimate that just prior to the Civil War, only 2-5% of slaves could read and write. While the literacy rates among African Americans would rise dramatically by the turn of the century (National Public Radio, 2006), they remained relatively low in the South a decade after the Civil War. It is worthwhile to consider power within a health care facility such as LPH in which all of the early patients and many of its lower-ranking staff were African Americans and were probably unable to participate in the record-creation process.

The information that the Superintendent used in his report was used not only to inform the Board of LPH's activities, but also used as a source in the Board's reports to the state legislature and governor. LPH's records, while often condensed to inform state officials of mundane hospital activities, were also examined on occasion in their original form, especially when there were shifts in the hospital's administration and financial questions arose.

In the early years of the hospital, the LPH Board underwent several upheavals due to the changing political climate of the area and the gradual total immersion of state facilities into a Jim Crow South. Whenever the Governor overhauled the Board, the new Board inspected the previous Board's records. The new Board members' examination was in part to assess the state of affairs of the hospital before developing by-laws, as well as to point to the previous bureaucratic regime for any mismanagement and thus excusing themselves from any blame if the institution floundered fiscally for a while under the new Board. In March 1882, the Board made the following resolution:

> Resolved. That the President of the Board be authorized to appoint a Committee of Three whose duty shall be to investigate the condition of affairs at the Asylum and to enquire into the situation of the books, papers and records of the Institution and if they see fit to take proper Inventories of such articles as are to be turned over to the newly elected Officers.

The "books, papers and records" of LPH were the way in which the investigative committee could determine the hospital's current "condition of affairs." At the conclusion of these inspections, their findings were reported to the Board and recorded in the minutes. Any errors on the part of the past Board in maintaining correct records were noted in the minutes.

Later the same year, the Board met to discuss the state of affairs at the asylum. In addition to finding that the former Superintendent had sold a pair of horses that the hospital greatly needed, they also discussed what they discovered from looking at the financial records:

> We have examined quite closely (notwithstanding our time has been limited) all of the books and records kept by the Officers and employees of the Institution. We find them so far as they go well kept in every regard. Our investigation has developed the clear necessity of keeping one further Book at least viz a Cash Book which is not kept at this time. The "Check Stubs" which are foreserved, the "Bank Book" and the "Day Book" supply to a limited extent the necessity to which we call attention but by no means do we find them all that is proper. We further recommend that if necessary you, by regulation, require the new Officers to keep such a book to be added the "Cash Book" which will show at a glance the items of case expenditures made and like items received and as clearly and promptly the financial situation of the Institution.

Rather than focusing on any specific instances of fiscal negligence on the part of the past Board or Superintendent, the committee in charge of looking at the financial records were critical of the recordkeeping itself, especially what types of records were not being kept. While the records they found were "well kept," the committee also found that the available financial records, e.g., the Bank Book, were not "all that is proper." Here, "proper" can refer to two different meanings of the word: "accurate" and "complete." The two definitions are connected in the recordkeeping context; a thorough account of the hospital's finances is also a correct one. Thus, the committee recommended the maintenance of a "Cash Book" in order to have all of the financial transactions recorded in one place. They emphasized the need for a recordkeeping system that allowed for quick and easy reference "at a glance," suggesting that the committee struggled to find the information they sought in the short amount of time that they had for their investigation. Two years later, in 1884, another newly instated Board resolved that the Executive Committee will receive "all the property of the Asylum from the present management and install the new officials, and that they be authorized to employ an expert to ascertain the assets and liabilities of the Institution." Inspections of the LPH's records to determine the hospital's assets were of particular importance to the Board during 1870 to 1885 when it was uncertain if the state would continue providing adequate funds to the institution.

The Board's investigations of the hospital's financial records extended to the records created by specific employees in an attempt to examine those individuals' decisions and actions, as well as explain ongoing fiscal concerns. In March 1883, the Board created a committee to study the Steward's purchases in order to check that he was ordering the correct supplies and that the hospital was receiving them. The appointed committee was "empowered to summon witnesses, examine books, papers &c." It is not noted if any testimonies were taken, but the committee came to the conclusion based on their findings from the records, or as they say, "in view of what we find to be the status of the record," that the Steward had been paying too high of prices for goods. They did not wish to "charge any indiscretion on the part of the Steward," but they strongly advised the hospital administration to take "measures" that would ensure it would receive the best prices as possible. Then in a July 1884 Executive and Building Committee, a board member noted that a member of the "late Board" made a "plain error in figures & facts" in his report to Legislature of the total cost needed because he "made no allowance for pumps, fencing, Architects pay, Gas Machine or piping, Iron work of Cupola, Iron Guards, Bake house & oven, Stables &c, Drainage, Advertising, Grounds or Roads." The minutes note that the current Board, as a result of the former member, was not able to secure the proper appropriations that would have allowed them to build two infirmary wards at LPH.

The inspections of the previous Board's recordkeeping practices invariably resulted in calls for changes to the hospital's recordkeeping practices that would help strengthen the current Board's authority. In the last administrative shift of 1870-1885, the Board in 1884 made a resolution regarding the long-term preservation of official records that would help establish itself as a legitimate power in the eyes of the state, the local community, and the hospital administration:

> Resolved that the official oaths and qualification papers of the Board of Directors and the officials be placed in the hands of the Clerk of Board for safe keeping. In accordance with this proposition the following official papers were placed in the hands of [redacted], Clerk […] The clerk of the

> board was further instructed to have the official oaths of the Board recorded in the County Court of [redacted], and to pay for recording the same out of the funds of the Asylum.

The preservation of the oft mentioned "official oaths" by the Board's clerk and county court was one way in which the new Board could ensure less disruptive reorganizations. Transitions in state government, whether governors or legislators, has throughout the history of LPH's existence caused administrative ripples that affected every aspect of the state mental health care system, from major changes in the Board's membership to the management of patients. Decisions by federal agencies such as the Freedmen's Bureau and legislation such as the Civil Rights Act and HIPAA have also caused less frequent, but just as powerful and even more disruptive effects on the hospital.

The constant shifts in actors and political powers within the state government especially are noted by Janet S. and Dennis H., who were both LPH administrators at the time of our interviews. Janet S., in reference to the challenges of lobbying for improvements at LPH, says that with the current term limitations for some state officials, "Continuity is difficult." The desire for stability in state and hospital leadership is reflected in multiple recordkeeping efforts in which records are used to give institutional operations (i.e., human actions and relationships) the appearance of deliberateness and constancy. These efforts range from the aforementioned preservation of the 1884 board member oaths to the editing of reports to the belated seeking of form signatories.

Consistent records mean that there is a "legal story" in place that "legitimates the actors performed as well as the costs" to third-party providers (Berg and Bowker, 1997, p. 524). And while the existence of records is critical, the documents were not necessarily created sequentially, e.g., forms were signed outside of the correct workflow. I found through my observations of the order in which information appeared to be entered into the registers and my interviews with staff regarding their record-creating practices that it was less important that the order of operations for administrative recordkeeping be

correct than that the final records reflect the "preferred accounts," which present medical efficiency and assuredness (Berg and Bowker, 1997, p. 525).

The preference for uncontentious accounts by LPH administrators is clearly voiced in the records as early as 1872 during the Board's preparation of an annual report to the General Assembly. The minutes state, "The Superintendent proceeded & read his report. While reading the report he called particular attention to several passages, & asked to be instructed by the Board whether to retain or erase them." One of the passages in question was in reference to a potential real estate deal, and the other was about a patient killed by another patient. The Board decided the former would be omitted from the annual report, and the latter was left to the Superintendent's discretion. The patient registers also indicate numerous edits and corrections made during 1882 and 1883. The by-law calling for the Superintendent to maintain a patient register was passed in 1882, thus telling us that the entries prior to 1882 must have been culled from other document or documents. The neatness and lack of errors for the 1870 to 1882 entries support the idea that the processes for entering patients' information before and after 1882 were different.

The type of clerical errors starting in 1882 suggest that batches of patients were entered into the register at one time rather than individually. Information was often written on the wrong lines or for the wrong patient, but would be corrected later. In a memo on March 3, 2013, I wrote:

> I'm discovering how difficult it is (à la Barthes' "Death of the Author") to "know" what the author was thinking, especially not knowing who the author was in terms of his/her position in the hospital, the chain of command, and the recordkeeping practices beyond the patient registers. The timing of the admission recordkeeping is especially frustrating because it's clear that each entry was not initially written or maintained on an individual basis. The recorder would enter information for several patients at once, thus leading to some clerical errors that were caught but nevertheless recorded for posterity.

Examples of corrected errors from the register during that time include the information about a male patient that was crossed out by the same staff member who wrote the original entry. The employee wrote the words "Entered by mistake" and, in order to maintain the accuracy of the patient count, he entered the information of another patient – this time a female – into the otherwise unused correspondence section. It was common practice to use the correspondence section to register other patients when clerical errors were made; the limited space, however, offered room to write only abbreviated information about the patient such as name, age, county, receive date, form of disease, date of death, and cause of death. In 1882, the maintenance of a register appears to have been a perfunctory task for long-term statistical purposes and not immediate patient care. Part of the medical staff's recordkeeping duties included correcting the register to ensure a chronologically accurate account of patients' admissions.

The practice of checking documents and fixing incomplete or incorrectly recorded forms continued throughout the 20th century. In my interview with Loretta M., she mentioned several instances in which she, as a clerk, had to send back patients' records that had been delivered to the medical records department because doctors would sometimes forget to sign the appropriate forms after patients had been discharged:

> I had to check the dates, you know, to make sure sheets were not missing, make sure forms had been signed that were supposed to be signed, because every once in a while, things would not get signed, make sure they get signed, just make sure the chart was in proper order and everything was as it should be.

With the increased movement of patients between facilities in the latter half of the 20th century due to desegregation, LPH's involvement with forensic patients, the rise of mental health clinics, and the shorter stays of patients (but increase in readmissions), forms that were associated with patients and moved with them when they transferred from facility to facility had to be notarized. Signatures were occasionally forgotten, and it was the clerks' responsibility to ensure that the forms were signed before officially registering individuals as patients of LPH. Loretta M. elaborates,

> We would look the papers over and make sure they were in correct order. Sometimes before the officers left, we had to make phone calls because we were not supposed to accept the patient at the facility if the papers were not in order. So before the officer left, we always checked the papers. Several times we had to call because on the back, there were two areas that had to be signed by the Judge and […] the Special Justice because most of them came on [temporary detaining orders].

The official handover of a patient, which was marked by the officers leaving, was delayed if the papers were "not in order." The documents served as proxies for court authorities. While some forms, such as the ones signed by the judges and special justices, controlled the immediate movement of patients, i.e., patients could not be transferred without proper documentation, other forms were decidedly less scrutinized until much later on. For example, longtime patients who were to be discharged after several years or even decades may have older records that need to be signed by a current doctor in order for their files to be considered complete and accurate and the individuals would be released. Such has been the case with Dennis H., who noted that he has received decade-old forms from the medical records department that still required his signature in order for them to considered complete and legally binding, "I'll sign some things from ten years ago that weren't signed when they should have been." In order to help explain why it became more likely for employees to forget to sign forms and why clerks were increasingly needed to check that all the paperwork was properly filled out and ordered, we need to examine the significant growth of bureaucratic record production at LPH, especially in the latter half of the 20th century.

The proliferation of records at LPH during the mid-20th century can be traced to several changes occurring at the hospital. During this time, LPH was expanding in population, in terms of number of both patients and staff members. The hospital also participated in the escalation of what we would view today as inter-organizational accountability practices with the state and federal government and medical associations. Recall Yates (1989), who observed a relationship between increases in an organization's internal communication and their dispersed records. The actors who produced the

paperwork associated with the rise in communication, medical work, and inter- and intra-organizational responsibilities were assisted by commercialized record-producing technologies such as the typewriter and carbon copies. However, note that, while recordkeeping technologies were allowing records to be produced and copied with greater speed during this time period, many organizational actors did not trust the provenance of typed records because these documents were easy to produce and difficult to verify their origins. At a hearing for a fired LPH employee in April 1956, the ex-employee presented letters in support of his good character. The minutes show that "It was pointed out that anyone could have typed up these statements, and [the former employee] then produced the original handwritten copies." To ensure provenance, the clerks and secretaries made clear if documents were originals or copies. For example, the surviving letters in the LPH archives regarding building construction in the late 1950s are all carbon copies. They bear handwritten or hand-stamped notations indicating if they are copies. There are also typed notations that tell us to whom the copies went.

In addition to the increased number of records being made due to changing recording technologies, administrative changes to address health and safety concerns such as overcrowding required more paperwork to be produced. According to the 1970 State Board minutes, a superintendent from another state facility developed a nine-step screening process for individuals seeking hospitalization that involved the reviewing of records and the creation of more. The process included examining the court's involuntary certification papers and sending out a geriatric questionnaire for relatives. If the individual was accepted at the hospital, approval letters were sent to the petitioner with a copy sent to court, and, if the person was not accepted, rejection letters and certification papers were sent to court with copies sent to Commissioner and petitioner and the individual's name was added to a rejection list kept in the hospital's admission suite. During this time, the state hospitals including LPH were moving toward deinstitutionalization and shorter hospitalization stays for patients; their increased interactions with the state legal system resulted in more administrative paperwork. While

the hospitals appeared to have a horizontal inter-organizational relationship with the courts in this instance, they had and continue to have a strictly vertical relationship with the state's central office.

The administrative staff that I spoke with for my research alluded to a preponderance of forms imposed by their superiors in the central office for mental health facilities. By "central office," I am referring to the state's department of behavioral health located in a nearby major city that appears to have risen in power and prominence in the state by the 1960s. In a February 1967 meeting for doctors to bring their grievances before the State Board and Commissioner, a physician from another facility said he and his colleagues were "thwarted by Central Office red tape." My interviewees' comments suggest to me that the heavy reliance on paperwork assisted the central office in its organizational relationships in two ways. First, the forms plainly helped the collective actor track the activities of its branches. The recordkeeping requirements stemmed from the state mental health care administrators' need to demonstrate fiscal responsibility to the state legislature. Recall Koppell's (2005) five facets of accountability, and note that all of the expectations of accountability that had been placed on the hospital also applied to the central office, albeit manifested differently in the specific goals, actors, and relationships. Loretta M. recognized the increase in paperwork from the time she started working at LPH to the time she retired a few years ago, "[A] lot of things weren't even required, I'm sure, by state laws that are required now." Dennis H. told me that legislators who earmark money for LPH to provide particular services for patients want to ensure that the health care providers are performing the allotted tasks. Therefore, forms become necessary and "in the end, it's about transparency, I think." Secondly, the forms implicitly assist the central office uphold its position of power over the individual facilities. To this point, I argue that the content of the form is less pertinent to maintaining the organizational hierarchy than the existence of the form itself and the administrative demands that it represents.

According to some interviewees, LPH has been the focus of the central office's "paternalism" in the past, in part because of the hospital's geographical proximity to the administrative center and because of past LPH administrative failures: "In a lot ways through the '70s and '80s, it was allowed to drift down if you just don't pay attention. And then, Dad comes home – paternalistic." One person I spoke with suggested the burden of being heavily monitored may also stem from the hospital's African American roots and having a different racial, financial, and social make-up from the other mental facilities in the state. As a collective actor, LPH complies with the central office's open surveillance and expectations for written accountability (cf., Haggerty and Ericson, 2000).

At the individual actor level among the LPH hospital staff, the paperwork requirements appear to be an accepted, if also time-consuming and sometimes seemingly unnecessary, part of working for a state agency. In the archival records, I encountered only one instance where an actor overtly complained about the amount of required paperwork at the hospital: in a discussion about the process to move people to new offices in October 1955, "Dr. [redacted] said that there were far too many forms being used and he couldn't see any reason for them. He thought it was a waste of time." In reference to more recent administrative duties, Dennis H. observed, "There were certain things that you have to do, and if you didn't do it, somebody, a bureaucrat, would come and say, 'You didn't fill out this form.'" The form in question was not used for any purpose discernable to Dennis H. other than for precautionary accountability purposes. Janet S., in recognition of being an administrator within a "giant bureaucracy," similarly sees herself as being entrusted with a large amount of responsibility from upper administration while also occasionally hindered by official procedures from carrying out seemingly mundane activities. While the procedural paperwork serves as the intermediary between LPH administrative figures and inspectors from other organizations to help inform the latter of the former's activities, the bureaucratic documents are also a collective representation of the ongoing relationship between LPH and its supervisors.

Accountability, as a social condition imposed on individual and collective actors in the public sector, is a necessary component of a state mental health system's political economy. Administrative recordkeeping is overwhelmingly to ensure financial responsibility, even if not explicitly portrayed as being for fiscal reasons. From the hospital's inception, LPH's financial accounts have been monitored by the Auditor of Public Accounts. These initial interactions between the hospital board and the auditor were part of a close relationship, in which the auditor was the hospital's liaison to the legislature and the one who directly gave state funding to the hospital. He would also advise the hospital about its financial expenditures based on his knowledge of the funding that the hospital would receive. The Auditor of Public Accounts continued to be a presence in the LPH board minutes through the 1925-1940 period, and the audits continued in the 1955-1970 era. It is noted in the minutes that the Board was praised by the auditor that "the financial records had been prepared in a neat and accurate manner." Later, the minutes noted other hospitals in the state being praised for their records and recordkeeping by the American Medical Association and the Joint Commission on Accreditation of Hospitals.

LPH was the first of the public mental facilities in its state to seek national accreditation. In 1968, the LPH Superintendent reported to the Board the process that he and his staff underwent in order to be considered for the award. According to the Superintendent, four of the eight of the "most important" areas examined in the assessment specifically involved documentation. In order for the hospital to pass the accreditors' inspection, "All records must be properly documented and personally signed by the person responsible for these records" and "Minutes of all committee, medical staff or department meetings must be accurately recorded with a record of attendance." These two requirements of "properly documented" records and "accurately recorded" minutes tell us that the act of recording alone is not enough for the Joint Commission. While the LPH Superintendent in the 1968 minutes did not offer an explanation of what constitutes an accurate document, I gathered from my interviews that the accreditors look for

specific benchmarks for different types of records. Robert L. described to me his experiences with the on-site process of working with the Joint Commission to maintain the hospital's accreditation. During the intensive four and a half day visit, a Joint Commission team that includes a psychiatrist, nurses, and engineer inspected multiple aspects of the hospital's operations:

> Basically, they would come by every three years for a full survey. And then in between, they would do an unannounced survey. So when they came, they basically looked at all aspects of our operations, both clinical and non-clinical. And they have specific checklist that they go through. They have their benchmark, practices, and numbers. So they pretty much knew what they were looking for, and they always looked for how well we are doing the continuous improvement because they expect us to have a structure, a process in place so we can monitor it, to produce desirable results using sort of like a control chart, within the range. […] They would give us a schedule that they'd see this, see this, this, this. Some are on site, some are documentation review, and some they would just go around and check with the staff, ask them questions to see if they know how to answer and in order for them to form an opinion to see how well you are doing relative to the expectations and standards.

Using words such "benchmark," "expectations," and "standards," Robert L. expressed the importance for LPH to match the quality of care of all other accredited facilities. The language suggests a constant linear progression of improvement, in which constant diligence is rewarded. Internally, the hospital staff must negotiate the balance of performing their daily tasks, which become familiar practices and therefore quick to accomplish, and the adoption of new and ostensibly better routines. The hospital as an institution may appear to be permanent and unchanging, especially when it has been part of a local community for nearly 150 years, but it is in fact always adjusting to changes in its ecologies that are imposed directly by other organizations or more subtly through weak relational ties. The practice of maintaining standardized records that meet the expectations of a more powerful agency (e.g., the Joint Commission) helps an institution such as LPH appear steadfast in shifting and overlapping political, fiscal, and professional environments (cf., Stoler, 2009).

The hospital's development of written policies and rules help govern daily operations and provide a stable environment for those who work at the hospital and a sense of trustworthiness to those who have a stake (e.g., patients' families, the State Board) in ensuring the institution is making effective and efficient decisions regarding the management of its resources and patients' care. The other two types of written documentation that the Joint Commission sought out in its 1968 inspection of LPH included "specific written policies for the prevention and control of infections anywhere in the hospital" and "written rules and regulations regarding the governing body of the hospital and the medical staff." While the latter type of documentation has been in the hospital board minutes since LPH's inception, the former type of written information is most likely born out of decades of state health facilities dealing with outbreaks of tuberculosis, scarlet fever, hepatitis, and typhoid. Both Joint Commission requirements involve the creation of documents that provide information and imply that individuals who do not follow the written polices and rules will be face negative consequences. It is a case of documents enforcing the hospital administration's expectations for its employees, as well as the duties of its own members. The infection policies have the power to mediate the relationships between medical workers and patients. The interactions between and among the hospital's administration and medical staff are also refereed by written regulations, in addition to tacit social norms.

The Joint Commission's expectations for rules and regulations from the LPH administration is illustrative of the top-down management throughout the state mental health care system. Just as the LPH hospital administration expects their employees to produce records and reports, overseers of state-wide mental health operations anticipate documentation from hospital directors and superintendents. To recall Berg and Bowker (1997) from the previous section on changes in materiality and format, they observed that those higher in the hospital organization hierarchy have greater power over the narratives they create in records. While physicians and hospital administrators have more autonomy within their own hospital environment in writing reports than the aides, for example, it is

important to remember that the former actors are also part of a larger state government bureaucracy and have to complete their share of structured forms. In thinking about the records and forms associated with each patient that comes through LPH, Dennis H., who is a doctor, recalled that the documents required by the Joint Commission and the Central Office far exceeded the number of records directly related to the immediate medical care of the patient, "And so what I'm saying is that even if I'm saving a life, five or six pages does me quite well, but the chart is 300 pages." Many patient records, Dennis H. notes, are administrative and immediately filed for potential future reference,

> So a lot of the record is to make sure it's there when somebody asks a question but it's not really about care. In some wards in some hospitals, they'll have two records and one of them will be active today and one of them is kind of closed archival, just the stuff that has to be there in case somebody asks about it. A sheet that says how many sweaters you had when you came in. I don't need that for care, but if you lose one, it sure is good to be able to go back and find that there's an inventory. So if it were up to me in the old psychiatric hospitals, not quite like it was in 1910, but I bet eight or ten pages would do fine, but it's kind of grown to this because there's a lot of regulations on top.

The creation of inventories for patients' possessions is a recordkeeping practice that has been around LPH since at least 1902, which is when it is first mentioned in the patient registers. A female patient first admitted in 1881 for religion-induced acute mania is said to have "one bundle clothing in store room" in her 1902 update.

A precautionary mentality has proven to be useful for LPH and its staff in regard to the creation and retention of records for evidentiary purposes. The one recordkeeping habit that runs strongly through the narratives of the staff members that I interviewed is their tendency to retain records that could be necessary to recount an event. In response to my question of why it was so important for the nurses and aides to document patients' daily activities in their charts, Cathy R. responded, "Well, in case anything come up, you had the records to go back to. In fact, that was really – as my director of nurses used to always tell us – CYA. We got the nurses' training. We said, 'Well, what in the world is CYA?' and she said, 'Cover your ass.'" Documentation about patients' health statuses

and care has been professionally valuable to Cathy R. a number of times. She says, "I had to go to court a couple of times. But all of my things were documented in the charts, so they read my thing, they told me I could go." Cathy R. implies that patients' charts protected herself (and by association, the hospital) by standing as evidence of correct care.

The LPH administrators that I spoke with echo the medical personnel in the impulse to save records that could protect their institution. Beyond the LPH records being a product of the work of actors to ensure that the hospital or individual employees are not legally at fault when problems arise, they serve as long-term proxies for actors' verifications, supporting or even superseding the actor's oral recollections during inquiries about responsibility. During the mid-1950s, a cattle scandal plagued one of LPH's sister hospitals. At a June 1956 State Board meeting, one committee member noted to another member,

> I do not recall that any of these contracts, verbal or otherwise, ever came to the attention of the Board or that the Board took any official action on them. However, my memory is not always accurate and I have therefore checked through the minutes of our Board meetings for the past twelve months seeking for confirmation of your opinion. I have been unable to find any end under date of May 19. I wrote to Dr. [redacted] requesting him to examine the records in his office to see if he could find any supporting evidence. Neither in his memory nor his records was he able to find such evidence.

In this case, the Board unsuccessfully sought minutes and personal records to determine how much the Board knew about the situation prior to it became public. While "evidence" in this context is not used in the legal sense, the Board is nevertheless attempting to gather information to establish a timeline of events. The speaker does not indicate a preference for written documentation or verbal recollection; however, he does express distress about not being able to recall specific conversations or agreements from memory.

In reference to his policy on document retention, Robert L. told me, "[M]y criteria is very simple. If there is a possibility that somehow down the road, I need to refer to it, then I keep a copy. If someone already keep a copy, I don't need to keep a copy." He noted his tendency to keep memos even if their value is not immediately obvious, "One of the facility directors said, '[Robert L.] kept every single piece of paper.' Because when they asked me, I could always retrieve something." When I asked Robert L. why it was so important for him to be what he describes as "pretty compulsive in keeping forms" for the Joint Commission, he replied, "Because they want to make sure what you tell them is actually the truth. And this is a probing. They want to find out whether you have set up such a system or not. If you have such a system, then you must be able to show me, remember the process, the structure." Betty T., who described herself as packrat, related an incident about a visitor injuring herself while on the hospital grounds. Betty T. expressed how her intuition and experience told her to retain the memos pertaining to the event, "But sometimes there were things that you'd look at and say, 'Eh, I think I better keep that one.'" According to Betty T., the saved memos became useful, "Well, years later, now she wants to sue. And we said, 'But she did it to herself.' You know, we told. And it was all written down. We had memo after memo and stuff what happened." Similar to Cathy R.'s description of relying on patients' records in court, the critical element of Betty T.'s story are the memos. The verbal recollections of the staff alone are not enough to prove the hospital's lack of legal liability for the incident. Rather, different institutional communities of practice (e.g., medical and legal realms) have imbued actants in the form of written memos with the power to be understood and accepted as evidence of past actions (cf., Appadurai, 1986).

Information Workflows

In this subsection on power and accountability, I focus on how hospital records participate in information flows within the hospital between departments and individuals, and between organizations such as LPH, its sister hospitals, and the central office. By

information flows, I mean, the ways in which documents and information travel between places and people over time. The records are both participants and illustrators of the highly hierarchical structure of the organizational actors involved in state mental health care. I concentrate on the last era, 1955-1970, for this subsection because both the records and the interviewees' recollections from that period most strongly elucidate the manner in which documents reify the horizontal and vertical relationships between collective and individual actors at LPH and the larger, state-wide mental health care ecology. The shared physical documents, document forms and formatting, and classification systems used in records all contributed to the stratified communication and relationships between actors.

I discussed in my literature review the sociology of classification, especially as used in the medical fields, and how classification is a boundary object that can both go between different social worlds for communication purposes and be used by each world in a unique manner. Berg and Bowker (1997) note that patients' care information is integrated locally, horizontally, and vertically by groups within the health care community. In order for the groups, such as the state hospitals and community clinics, to be able to communicate with one another, they use classification schemata (e.g., legal status, DSM categories) as shared languages. All of the records that I examined had classificatory characteristics, whether the labeling of patients in the registers with diagnoses or the separation of the mentally ill and the mentally disabled in the meeting minutes. The records that utilize classification schemata are, like the classificatory elements, also boundary objects.

The LPH documents that I use in my research are most closely aligned to three of the four types of boundary object characteristics offered by Star and Griesemer (1989).[48]

[48] The fourth type of boundary object described by Star and Griesemer (1989) that I do not use here are repositories, which they broadly define as places where heterogeneous objects have been brought together in an orderly fashion so that people with different needs can come to one place and selectively use an object or objects. They cite museums and libraries as examples, but not archives.

One feature is the standardized form. This type of object allows a "common communication across dispersed work groups" (p. 411). The LPH registers share their appearance and categories with the registers from the same time period of the other mental health facilities in the state and most likely nationally as well. The blank registers and their preprinted categories also embody the second characteristic of having coincident boundaries, meaning that they are objects shared by different groups (i.e., different facilities), but are used in different ways. While hospital personnel, regardless of where they work, have a shared medical vocabulary, I argue that the registers nevertheless have "different internal contents" (p. 410) and potentially different purposes because of the specific record ecologies of each hospital. The meeting minutes are another example of a type of boundary object with a standardized form, albeit in a way that is less obvious in terms of predetermined categories and formatting. The LPH minutes were written throughout the different eras in particular fashions that were popular at the time among committees.

The standardized appearance of hospital records leads us to the third boundary object characteristic, of the ideal type. According to Star and Griesemer (1989), a boundary object that is an ideal type is an abstract concept that local sites can adapt for their own use while still being able to use it to communicate across sites. The effective and seamless integration of different boundary objects, whether classificatory language, record formats, or record media, across diversely organized groups rarely happens, though. Thus, for example, while all members of a particular profession such as registered nurses, regardless of their specialties, will have learned the Nursing Intervention Classification cross-institutionally, non-nursing staff may not comprehend that type of classification or have access to the records that employ such a system. In other cases, potential boundary objects such as systems of communication and practice that are employed by one facility may not be easily understood by another, especially if the workplace ideas, objects, or actions are de facto ones established internally by the former over time. Finally, a potential problem of having an ideal type boundary objects in

a state hospital system stems from disparities in socio-economic resources and differing hierarchical relationships between the central administration and each facility. The required recordkeeping practices and the common forms imposed by upper administration on state facilities, including LPH, at once help the different facilities maintain horizontal relationships with one another while also potentially aggravating and making more evident the historical inequalities among the institutions.

Based on data from the registers and minutes, the horizontal communication with the other hospitals in the state during LPH's early years was uncommon. In fact, LPH personnel appeared to have more interactions with other institutions outside of the state in order to learn about architectural and care innovations. In 1871, the Superintendent participated in the annual meeting for the Association of Medical Superintendents of American Institutions for the Insane, and the man holding that position was expected to attend similar conferences in the subsequent years. Since LPH was the only mental hospital in the state that served African Americans, the transfer of patients rarely happened between LPH and other facilities in the state. The hospital superintendents occasionally gave gifts to one another or traded goods. In May 1926, another state hospital gave a bull and heifers to LPH. In 1928, four LPH patients with general paresis, a neuropsychiatric disorder caused by syphilis, were inoculated with malaria, a common treatment at the time. The malaria donors were patients at another hospital. During the 1930s, LPH exchanged bushels of sweets potatoes harvested on its grounds for apples from another hospital. It was not until the State Board assumed power in the late 1930s, however, that the superintendents of state mental facilities met regularly to discuss the daily operations of their hospitals. The State Board implemented policies, guidelines, and forms to encourage uniform administrative and medical practices.

Although it was outside of the scope of my dissertation research to examine the records of the other mental health facilities in the state, I did find evidence in the State Board minutes of the same types of recordkeeping requirements being imposed by the central mental health administration office on all of its facilities. The period 1955 to 1970

can be characterized with a growing attempt to have the same type of records and recordkeeping practices across all of the mental health care facilities in the state, even though the hospitals have disparate patient populations, whether segregated by race, age, or illness, and are consequently not equivalent fiscally or in terms of the quality and number of staff members.[49] Part of having shared recordkeeping practices meant having similar type of commitment forms and admission registers. Minutes from the State Board meetings were distributed to all of the state hospitals to keep for their records. It also meant documents such as best practice manuals were prepared to be adopted by all of the state facilities:

> The Commissioner presented a Manual of Instruction for Nursing Personnel prepared by Miss [redacted], Director of Psychiatric Nursing. The motion was made, seconded, and adopted, that the Manual be approved, that it be distributed to all personnel concerned, and that it be revised from time to time as determined by our professional people.

Note that the division of labor cuts across all of the state facilities. By approving a manual for all psychiatric nursing staff working for the state, the Board indicated that it expects consistency in workplace practices regardless of the facility. Furthermore, unlike during the first era of the hospital in which the superintendent was also the lead physician and therefore held both an administrative and medical position, the Board was entrusting their "professional people," i.e., the nursing staffs, to determine how best to conduct their daily practices, albeit only after the Board had given them its initial approval.

Changes in the administrative structure during this time resulted in the State Board, which consisted of hospital superintendents and prominent members of the community (e.g., judges, lawyers, military officers), relinquishing power to the central

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[49] In the same state as LPH, there was a treatment center for children, which had a patient reimbursement rate controlled by a separate statute. Therefore, in 1969, while LPH was being reimbursed for $189 per patient per month (the lowest rate of all of the facilities), the children's center received $900. The latter, however, did not have the highest reimbursement rate; a relatively new facility that treated acute mental illness cases received $1,200 per patient monthly.

office that oversaw all of the mental health care facilities in the state. I observed a lack of downward vertical communication in September 1956 after the state mental institutions fell under the Division of Mental Hospitals. In addition to the monthly Board meetings increasingly taking place at the Division's office by the late 1950s rather than rotating between the different facilities, the Board no longer had control over certain genres of records. The centralization and stratification of administrative information gave the central office power over the Board and the facilities. The Board minutes indicate that the disruptive change in the governing structure of mental institutions led to confusion among the Board members regarding who was in charge of personnel records, including those of the relatively new clinics that were beginning to take on classes of individuals that the older large institutions were increasingly phasing out, e.g., the mentally disabled, the elderly, and children:

> [A Board member] asked if [the Director of Division of Mental Hospitals] was in charge of the records for Medical and professional personnel. The Commissioner said they had taken over all the personnel records. He said he did get back part of the records for the people coming directly under him here in the Department. The records for the other personnel in the Department have been taken over by [the Assist. Dir. Div. Mental Hosp.]. He said he was concerned over the fact that they took over the records of the personnel at the Clinics also. They have taken the position that the Clinics are in the same category as the Hospitals. The Clinics operate under funds appropriated to the Department.

In discussing their loss of control over the personnel records to the central office, the Commissioner and the rest of the Board indicated that their power to oversee and determine personnel decisions was gone. Notably, the clinics were now no longer considered to be under the control of the individual hospitals, but rather viewed as their own entities directly overseen by the central office. The clinics became commensurable with the much larger facilities that are also "coming under the Department." The Commissioner gave a fiscal justification for the administrative reshuffling when he noted that the Division of Mental Hospitals now directly funds the clinics. At the same meeting,

Board members also discussed their trouble in accessing financial information then being prepared by central office personnel:

> [A Board member] asked if there would be a summary financial statement for the Board at its next meeting. [The Assist. Dir. Div. Mental Hosp.] said he could not answer that, it would probably be the end of the quarter before the new reports would be ready. [A second Board member] said the report as submitted to the Board did not tell very much and felt that the Board should have a complete financial report as heretofore. (This matter was discussed further in executive session.)

The shift away from the Board having easily accessible financial information is both a consequence of and a means for the central office to enforce their authority over the entire operations of the state's mental health facilities.

Meanwhile, during the same time period, the State Board continued to demonstrate its managerial power over the individual facilities by discussing agenda items regarding each institution even if a representative, such as a superintendent or steward, from that site was not present. In addition to the consolidation of authority under the Board, there was also the recognition by the end of 1955 that the work of superintendents and the work of stewards were distinct to the point that they should not have meeting together at the state level. The stewards began their own meetings to discuss matters specific to their position. Therefore, there was a consolidation of authority at the state level and an increased distinction made between staffing types at the hospital level. By separating the stewards' business from that of the superintendents and the Board's, the former were no longer active participants in the latter's discussions and decision-making. The stewards became less privy to the information shared among the upper administrators. Conspicuously, the stewards' meeting was not led by the stewards themselves, but rather by the Director of Hospitals and his Deputy Director. It is unclear after this reported meeting if similar steward meetings took place. The minutes indicate that the stewards continued to participate in the State Board meetings until the late 1950s, albeit with attrition, and then their position appears to have been renamed in the minutes and organizationally as "Administrative Services Directors," followed by "Assistant

Supervisor – Administrative." By the late 1960s, the hospitals distinguished between administrative and clinical positions so that there were clinical assistant superintendents and administrative ones. Finally, by October 1969, the administrative assistant superintendents were no longer present at the board meetings.

The third and last era of LPH records show us that the personnel rankings and duties were becoming increasingly regimented and discrete because of the growing complexity of legal and financial bureaucracy surrounding state mental health care. While the tasks associated with different types of staff at LPH, e.g., nurses and doctors, stewards and superintendents, were distinct from the hospital's start, as seen in the its early by-laws, the rise of administrative work practices contributed to the creation of more positions and distinctions within those rankings (e.g., Clerk Typist A, Clerk Typist B). The hierarchical distinctions between hospital staff is observable in both person-to-person interactions, as seen with the separate steward meeting in 1955, and the recordkeeping workflows. Administrative and medical record workflows, in tandem with the formalization of separate administrative and medical staff positions, became geographically separate on the sprawling LPH campus.

By October 1956, LPH had over 4,500 patients (compared to the 2,500 patient average at the all-White patient hospitals in the state) and the Capital Outlay Commission was working to develop new sites and buildings for much-needed expansion. In order to accommodate the planned hiring of 25 to 35 new doctors, the Commission looked to an unconventional type of hospital construction plan, in which the doctor's offices would be in the administration building rather than in the same buildings as the patient wards. While the doctors would have to walk to other buildings to visit patients, they would go to their offices in the administration building for "office activities such as dictation, etc." The doctors' offices became explicitly for recordkeeping purposes and were geographically separate from their medical work with patients. Indeed, just as records take space in the medical records department, recordkeeping as a workplace activity increasingly began to occupy space within the institution that was removed from the

record subjects (see Illustration 10). The sheer bulk of records at the hospital, and the acts of creation and storage of these documents, helped in mediating the ongoing interactions and relationships between two actor groups, the record subjects and the record users. Administrative record production contributed to the growing physical and social divide between the administrative world and the medical world of LPH. Individuals of different medical stations at LPH, e.g., doctors, nurses, aides, had their own sets of forms that they were required to fill out for administrative and medical care purposes. Each member of a treatment team belonging to a particular medical specialty (e.g., psychiatry, physical therapy, nutrition) had his own set of documents. Loretta M. told me, "[Members of] every discipline have all their forms that they go by."

Illustration 10: Files in the hall of the original administrative building, 1955. Image: LPH Archives.

The potentially fatal implications of the inability to share information between two medical staff members because the individuals are of different statuses in the

workplace and consequently have separate record workflows can be seen in the 2014 case of the first case of Ebola in the U.S. The man who tested positive for Ebola had been released previously from the Texas hospital he first checked himself into because the doctor was unable to see the nurse's earlier notation that the man had traveled to Africa: "The statement said that the 'documentation of the travel history was located in the nursing workflow portion' of the electronic health records and 'would not automatically appear in the physician's standard workflow'" (Bever, 2014). Recall that I discussed in the technology section of my discussion the adoption of new health recordkeeping technology can greatly affect information workflows and medical practices. When only paper-based records were used at LPH, documents were collated together by a clerk to make up the patient's case file. As noted by Dennis H., the drive for an electronic health record has not matched the medical information needs of health care providers. Recordkeeping practices, whether electronic or not, sometimes do not accommodate the multi-disciplinary and collaborative environment that occurs in daily medical practice. It is important to remember how the embracing of new record-making and -keeping technologies, such as microfilm and Avatar, meant the destruction of old records or ceasing of old technologies and the potential for information sharing to become more difficult rather than easier.

Objects such as records mediate relationships, especially how people communicate and determine how people are treated professionally, medically, and in informal day-to-day interactions. For some personnel such as Loretta M. and Betty T., record creation and management was the basis of theirs jobs. Their work was predetermined by the institutional flow of documents and work practice needs of other people at the hospital (e.g., doctors) and outsiders (e.g., lawyers, the governor). Daily tasks became easier the more staff members understood the entrenched systems being used. Although on-the-job training contributed to new employees learning how the hospital functions, informal social networks, and learning-by-doing appeared to also be critical for working successfully at LPH. In discussing the challenges of introducing

institutional knowledge to a new administrator hired at the hospital, Robert L. notes, "Quite a number of folks my age, we all grew up together, grew old together in the bureaucratic system. […] So we have that advantage – that informal, well, sort of, in the South, they call it the old boys' system." While Robert L. calls it an "old boys' system," for recordkeeping practices, this type of social capital could perhaps more accurately be called an "old girls' club."

Based on the data from my LPH research, I found that individuals who held historically gendered administrative positions at LPH (which remain predominantly "pink-collared" today) and had a wide breadth of experience with the recording and distribution of information in the various hospital departments held a kind of power that is not recognized through LPH's formal organizational hierarchy (e.g., position titles, salary).[50] Recall Dandeker (1990) and Yates (1989) who argue that the most effective way for an actor within a bureaucracy to make decisions, manage, and otherwise hold power within her organization is to have a thorough understanding of its files and the internal movement of information. The women who were LPH clerks, a position title later renamed as administrative assistants, were the personnel who were most familiar with record formats, the order of the records, and recordkeeping processes. I argue that the women who were well-versed in the flow of records in their workspace held more power in the hospital personnel hierarchy than their position may have indicated. Their

[50] From the early years of the hospital and the employment of a Matron, LPH has always had female personnel, especially to care for the female patients. Women began holding clerical positions by 1925-1940 when female stenographers were employed at LPH, and in July 1935, a female medical record clerk was hired. In terms of leadership positions, the first woman became an administrative service director in March 1958. Interestingly, while she became a longtime member of the Board, she was listed as "Mrs. [husband's first name then last name]" and her first name was never given. In March 1962, the first female State Board member joined. She eventually became Chairman of the Board in 1969 after the previous chairman unexpectedly died, but like the administrative service director, her first name was not recorded. Then in March 1968, the first woman superintendent appeared in the minutes. She was in charge of the children's facility. Unlike the other two women on the Board, she was probably unmarried as her first name was listed.

knowledge of LPH's particular recordkeeping practices was invaluable in the sense that over time their knowledge made them difficult to replace as they moved further up the administrative hierarchy.

As a clerk for the steno pool and later as an administrative assistant for the hospital director, Betty T. noted that the recordkeeping needs of her superiors were of foremost importance in her daily duties. During her time working in the steno pool starting in 1960, it was composed entirely of women, and the immediate supervisors were also women. The concurrent rise of the typewriter as a recordkeeping tool and the hiring of female clerks to handle all recordkeeping matters at LPH meant that the doctors relied on the typists to transcribe their audio recorded notes. Betty T. says, "We typed all of the notes that went into a patient's record, which now [the doctors] just write them in." Betty T. recalls the stenography room resembling a classroom in appearance and atmosphere. The supervisor "sat up front and she was almost like in a cage but it was glass around it"; she would tap on the glass to remind the girls to sit up straight.

According to Betty T., the steno pool was composed of "three rows of girls" who were Clerk Typist Bs. In describing the typists as all working for different doctors in different medical fields, Betty T. demonstrates how the typists were what Yeo (2007) describes as "authorized proxies" (p. 337) in that each woman stood in for the doctor by being responsible for transcribing his words: "You had the psychologists, the social workers were back here, and then medical directors, you know, the medical work was down up here and the social work back here. And psychologists, you know. Girls did different things." Besides conflating the clerks with the doctors they typed for in the steno pool, Betty T. also described secretaries in a way that suggests they were surrogates for their bosses, at least in terms of managing their administrative duties. She says, "The first thing you did, it was for your doctor. No matter what else, it was your doctor at this point. And you had to answer the phone, you had to know where he was, or what was happening." Like the LPH doctors from the 1960s who needed the steno pool typists to create their official medical records, the hospital administrators were reliant on the

women who handled their daily recordkeeping tasks. The work of these assistants often occurred silently. As Betty T. explained,

> So [the Director] never really saw what I did. […] And he says, "Do you know how to use [the head secretary's] typewriter?" I said, "Well, let's see. Ah, turn it on. It looks like it got the same letters." And I said, "Yeah, I know how to work a typewriter." You know, I'm thinking, where's this man coming from? Anyway, so bless his heart.

The director was not aware of the work that Betty T. did daily, indicating that he perhaps did not fully understand who created the records and how the documents moved around LPH and to other organizations.

Loretta M. explained to me that her experience working in Admissions, Forensics, and Medical Records gave her a thorough knowledge of the filing order of case files and allowed her to be particularly good at her job: "Filing order in medical records is very important because a person can call, ask, request anything. [snaps fingers] As long as you know the file, you can go right to it, if you know what you got to find, what you know you're filing." In addition to being able to do her record management work quickly, Loretta M. was able to hold others accountable who handled the records outside of LPH. As a medical information release coordinator and a case file quality control checker, she held power over how LPH records and the information they contained were handled and used by potential information users and the microfilming vendors, respectively. As you may recall, Loretta M. worked with external vendors to microfilm case files. She was in charge of quality control to assure everything that needed to be scanned was done so correctly. Here, she describes how both her understanding of the filing order at LPH and the ways that the system has changed over time has allowed her to oversee the vendor:

> You get used to the order, the more you work with the records. You know what to expect, you know what you're looking for, you know what pages – and especially for people that have been there for a long time, we'd find them – you still know the order, you have to have a knowledge of the old filing system, as well as the filing system that we have today so that you can keep them honest and you know what you're looking for and if

> something's not there, you just say, "Wait a minute, where this?" Maybe there's a reason why it's not there. But you know at least you will catch it.

The notion that knowledge of the records and their correct order or how the records should be used is a powerful way to "keep [people] honest" is a Jenkinsonian theme that ran throughout Loretta M.'s interview.

During the latter part of her career at LPH, Loretta M. was also in charge of requests to release medical information. These requests could come from immediate family members, lawyers, descendants, court orders, reporters, and so forth. Although Robert L. told me that the information release coordinator "just basically follows the release of information policy" so that "it's not much [personal] discretion there," I believe it is evident from my conversation with Loretta M. that she was performing invisible work, and specifically disembedded background work (Star and Strauss, 1999). The duty of releasing patients' information – a job that Robert L. perceived as being procedural – required Loretta M. to make individuated and emotional decisions. She saw herself as a gatekeeper to the records who went beyond the procedural steps to assist people. I cannot confirm how, if at all, Loretta M.'s personal beliefs affected her decisions regarding who should be allowed to access medical information, but it is apparent that, for her, the legal right to access information corresponds with a moral worthiness and need of the information:

> I always felt like this information makes a difference in a person's life, and if I could do that in any way to help them, I always felt – we get social security, we get requests for those every day almost, every day. Sometimes people just believe just because I've been there and I can go get this – not so all the time. But I always felt good about it because that's the way of God. The person that needs their [sic] finances to help them live will get the money. And there were sometimes, well, if this person don't need it, because they didn't put a little more in it, they ain't going to get it. Because if they needed it, of course, they deserve it. But no, don't give it to them if they don't deserve it. Uh uh.

Loretta M. viewed the steps required for medical information requests (e.g., personal information that explains relation to patient, copying fees) as being crucial for determining if the person seeking the information was "legit," as the records are commodities that can be financially beneficial to some people. When I asked her if she thought the current LPH process for handling medical information requests was adequate, she believed it was because it "kept people from getting the information that shouldn't, and we did have people that tried to get some information that shouldn't." She acknowledged the impact that recorded information about deceased individuals could continue to have on living people

Administrative employees such as Loretta M. are arguably the LPH workers who historically have been the most aware of the record production and movements underpinning the LPH infrastructure. The personnel who created and maintained records daily as one of their primary duties were especially cognizant of the value of records and the work that documents do within an organization in helping people remember and communicate. Their own relationships with medical personnel and patients were mediated by the records and the records-creation and management processes.

The Record Subjects

In the subsection above on information workflows, I noted that the LPH administrative personnel I spoke with usually worked in places that were physically distant from the patients. These administrative staff members tended to have rare direct interactions with patients because of the separate buildings for clerical and patient care work. Betty T., in discussing her work as an administrative assistant in the administration building, illustrated how it was unusual for those who worked exclusively on the production and maintenance of administration and personnel records to encounter patients. She told me, "You would see [patients] just come around and sort of – they knew they weren't supposed to be in there. You know, that didn't happen that often."

Betty T. remembered one patient who came into her office on two occasions. According to Betty T., the man said to her, "'I'm around crazies all the time. I have to come here [the administration building]. I like to come out and talk to somebody who is not supposed to be.'" This encounter with a patient was at once surprising for Betty T., who says she was always aware "he's between me and a door," and an opportunity for her to recognize this particular patient as an individual and listen to his concerns: "He was a real nice fella, he wasn't aggressive and he wasn't really super crazy, crazy. You know, didn't seem like that type." Robert L., who spent much of his time as an assistant administrator walking the ground of LPH to meet with staff and resolve personnel concerns, similarly had only infrequent and inadvertent contact with patients, especially those he calls the "higher functioning ones" who were permitted grounds privileges during particular times of the day: "[These patients] may be allowed to roam around on the grounds for an hour and a half. And then sometimes, you know, I may be walking around either on the job or even after hours, they see me and then they like to chat with me."

Loretta M. also had regular interactions with patients that were an unintended consequence of her recordkeeping duties. Loretta M. worked as an Admissions Clerk for nine years:

> That's when I really learned about patients, because we got patients right off the streets. Back in '76, a lot of the patients came and they had not been medicated and a lot was going on with them when they came in. […] A lot of times once we did the paper work, after we did the paper work, then the aides would take them back and get them ready to see the doctors. And they would be in hospital gowns and robes until the doctor came in to see them. And sometimes, it may take a little time, especially if they came during lunch time or the doctor had another emergency on a ward that they had to assist with. So we talked with them.

Loretta M. described the times she was able to speak with patients during unplanned lulls in the admission process for new patients. The amount of time was dependent on the doctors' schedules, indicating the medical personnel's high professional and social rank

among the staff. The informal conversations with the patients and the admissions clerks appear to have arisen out of necessity since both sets of people were in the same room together and the patients were sometimes distressed. A fellow clerk who worked with Loretta M. "loved the patients" and was particularly adept at speaking with them and making them feel at ease. These informal aspects, or "emotional work" (Hochschild, 1983), of the admissions clerk position are not recorded in the official LPH records. The description of accidental interactions with patients told to me by Loretta M., Robert L., and Betty T. are brief windows into the leaks between social worlds at LPH.

The incidents also show us that, for many administrative personnel, it is not the patients who are the focus of their hospital work but rather it is the records. By concentrating on the record ecologies at LPH, we can examine the multiple actors, including the administrative personnel and the patients, who are connected through documents. The records, and the human work that goes into their creation, organization, access, and preservation or destruction, serves as a major framework for the activities and relationships at the hospital. As I discussed in the archival portion of the literature review, patients institutionalized at mental health care facilities do not always have agency, or independent thought. While some hospitalized individuals are cognizant of their actions and words, other are not. The latter are nevertheless contributors in the creation of their records. As the record subjects, or "implicated actors" (Clarke, 2005, p. 46), it is their bodies, minds, and behavior that are observed and recorded.

For this subsection, I examine how recordkeeping practices have affected the medical and social treatment of institutionalized patients who have been diagnosed as mentally ill or mentally disabled at LPH. At LPH, records were one type of actant that assisted the hospital's personnel in controlling patients, allowing a continuity of governance through changes large (e.g., administrative overhauls) and small (e.g., attendants ending their shifts). The records contributed to a culture of constant monitoring and social restraint. Registers, case files, and administrative paperwork all fit patients into specific categories and helped to sustain the classifications during and after

the individuals' hospitalization. Meanwhile, the hospital campus and buildings also served as environmental actants contributing to the patients' controlled activities and designated spaces. Before discussing the role of records, I will first discuss some of the architectural structures and hospital environments that contributed to the highly hierarchical power structure in which patients' bodies and actions are overseen by personnel.

In minutes from 1870, the Superintendent assured the Board that "We have been able to by the extra care in regard to ventilation, cleanliness and exercise to avoid the Evils that might otherwise have occurred, owing to the overcrowding." Among the U.S. medical community at the time, the LPH administration was recognized as an early objector to the common practice of using mechanical restraints indiscriminately on mentally ill or disabled patients. Rather than mechanical restraints, the hospital preferred to use various versions of occupational therapy, decades before it was called such.[51] The hospital's physicians in 1873 viewed "giving employment as a curative means." Patients grew and harvested crops, raised animals, sewed and mended, did laundry, and cooked in the hospital's early years. In 1871, the Superintendent reports, "I have been able to get in successful operation 3 shoe maker's benches. They serve to give employment to some, besides doing all the mending. On rainy days the Patients make shuck mats of good quality." Ann P. notes the problematic dynamic of having newly freed African Americans serve as free labor for the hospital.[52] Payment to patients for their work was discussed but not implemented by 1925; by 1965, patients' earnings were being credited to their

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[51] The use of restraints is still occasional in mental healthcare facilities, but the practice is highly regulated and done only under circumstances that fit within state-approved limits. These acceptable situations are of course socially malleable, and the state-wide regulations have changed over time. According to Janet S., when she arrived at LPH in the 2000s she assisted the hospital implement central office rules regarding "better risk management, risk identification, risk management, appropriate use of seclusion or restraint or restrictive procedures, and behavior plans."

[52] See footnote 16.

accounts, and the state hospitals were not receiving compensation for the patients' labor or goods.

By the second era, the hospital administration vocally supported occupational therapy, and especially its "re-educational feature" that would help some patients reintegrate into society. Only the sick, tubercular, or chronically invalid did not work. In 1925, the Superintendent requested an "Industrial Building," noting that "the primary object of an industrial center is to serve as a place of therapeutic endeavor rather than as a place in which to make valuable articles." Self-care and vocational training in "training schools" became increasingly popular for mental facilities that worked with the mentally disabled. By 1968, fewer tranquilizers and psychotropic drugs were being administered to patients than in the past few decades. In 1969, the U.S. Department of Labor agreed with the hospitals that occupational therapy was indeed therapy rather than employment, as assigned tasks "are primarily for the therapeutic value to the patient and to the potential rehabilitation of the patient who would otherwise become a vegetable mass and whose life span would be considerably shortened were not some duty assigned to him." Patients were at once being prepared to rejoin society by learning an occupation while also remaining under supervision and confined by the hospital's built environment.

Although most patients in LPH's early era certainly had more physical freedom than if they were instead left in prisons or poorhouses, their movements were nonetheless controlled by environmental structures and the constant possibility of being watched. The Superintendent in 1870 "Called the attention of the Committee to the necessity of having iron grating in the cell windows," and in 1873, the "Executive Committee has authorized the erection of an isolated ward with 15 cells, to be occupied by the worst cases." It was clear by the early 1870s that the Board sought to construct a panoptic environment so that personnel could observe patients without being seen: "Iron doors of open work are to be

placed in the cells in the section allotted to the worse class patients which will enable the officers and attendants to observe the occupants at night without disturbing them."[53]

While the hospital administration's intent from the start was always to rehabilitate mentally ill and mentally disabled individuals so they could one day be independent members in their communities, the staff closely monitored and restricted their patients' activities and behaviors within the hospital. After a patient escaped in 1955, LPH administration made a new policy so that, when patients left the occupational therapy building, they were "now not only checked for scissors and sharp instruments but also for needles and thread and any other O.T. equipment." It was not until 1957 that an LPH doctor suggested that all of the iron bars on the windows be removed. Around this time, Cathy R. became a nurse at LPH. When I asked her how she was able to deduce that music helped pull patients out of depressions, she responded, "Well, just watching. Just observing. Because, see, where the nurses' station was, it was all in glass and you could see all – the whole ward – you could see everything." From one location, Cathy R. was able to see the entirety of the sitting area, which patients occupied during the day because the sleeping areas were locked and off-limits. The patients could also see her watching them. Interactions between nurses and patients were mediated by the glass-enclosed nurses' station.

When we look at records, another type of object, we can see how these actants facilitated the relationships between hospital personnel and patients. Arguably, the arbitrating effects of records reach much farther than structural actants such as the nurses' station because records are mobile objects that emerge from a co-creation of many actors and ideas: medical personnel and their training, administrative staff, the patients and their

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[53] One piece of evidence from the second era suggests that the patients were even on public display during at least the Progressive period. In 1933, "The question of the general public visiting wards in which are disturbed and untidy patients was brought to the attention of the Board. After discussion of this question, it was the opinion of the Board that general visiting should be permitted only to such wards as those designated by the Superintendent."

bodies, and regulatory organizations. The personal patient information that is recorded or not recorded and the types of required forms used – and how these documents change over time – are indicative of developments in psychiatry and state and federal administrations. And as a result, the hospital records affect the way people perceive and judge patients both inside and outside of the hospital.

Berg and Bowker (1997) point to administrative activities that have often unacknowledged consequences for patients while they are hospitalized. For example, they observed that the body is "rewritten in bureaucratic format" according to the schedules of the hospital staff, the daily workplace rhythms of the hospital, and the record requirements for financial administration (p. 519). In other words, the information about the body that is written in the record cannot be separated from the social structures and power driving actors to create the document. The records are the products of everyday bureaucratic business being conducted in hospitals. They are incorporations of observations of the body and the mind that are guided by prevailing medical thought, administrative reporting requirements, and the individual actors involved in record creation. The documents in turn alter how hospital personnel and other authority figures interact with patients, which can then change the record again.

In order to give a broad illustration of the discursive relationship between record production and patients' care, we can look at the patient admission registers. As I discussed in the section about the registers as a genre type, these documents were used primarily for administrative purposes rather than care especially after the introduction of individual patient case files at the turn of the 20th century. The registers were an efficient way of sorting and accounting for newly admitted patients according to their initial diagnoses (cf., Grob, 1983, and his discussion of Kirkbride architecture that helped separate classes of patients). Thus, patients who were considered to be of the "noisy and violent class" were housed in wards separate from the quiet and neat patients. Tuberculosis patients were kept far away from others. Male and female patients were also kept apart as much as possible. Over time, the purpose for the registers and the categories

to help classify patients – both formal and informal – changed over time to adapt to the needs of the admissions staff, state-wide policies, and the hospital's changing relationships with legal and other medical organizations. By the second era, patients' Wassermann's results were included informally in the registers, and, by the third era, legal statuses of patients appeared as a formal category. Official records, such as the registers, pigeonholed patients into the classifications being used at the time and affected where they were geographically located in the hospital, with whom they associated, and how they were medically treated. While the registers were not the primary documentation that medical personnel used in the 20th century to learn about or to facilitate interactions with patients, they were for some of the administrative staff and for those outside of the hospital seeking information about patients. The registers were important actants that stood as representations of the patients, albeit skeletal ones that told only part of the story.

While I did not specifically focus on case files for this research, several interviewees discussed the changes in the quantity and types of information required in patients' files. These former and current hospital personnel all note the increase in information that is now being included in case files. Recall Dennis H. estimating that he relied on only five or six pages of a 300-page chart for treatment purposes. Janet S. points out that the "medical records now are so detailed because of regulatory requirements, because of risk management." Modern case files give detailed information about patients' behaviors and social histories. Loretta M. remembered the changes she observed happening in patients' case files during her 36-year career at LPH as a medical clerk:

> Years ago, back in the '70s, and even before I started working, there was very little information. Very little information taken. Whereas now, I mean, they want to know everything about you. And it's good because the more they know, the more that they've studied and find out about the patient, they will be able to treat them better. And I'm not saying they didn't treat them well during that time, I'm sure they did the best with what they had. But of course the more they've learned over the years, they've been able to treat the patients much, much better. Now, they learn a whole lot about them.

Interestingly, while Dennis H. and Janet S., who are administrators, focused more on the bureaucratic reasons underlying case file expansions in their interviews, Loretta M. emphasized the relationship between when medical personnel began collecting and recording extensive information about patients and the noticeable improvements in individualized treatments and care. The multiple purposes for active patient case files, which are composed of many different documents created by different actors, speaks to the reach of records into all aspects of the hospital's operations; I argue it also supports the notion that records, when no longer being used for their primary institutional purposes, can continue to have a myriad of uses and values. The LPH records, inclusive of the case files and registers, continue to mediate our understanding of LPH patients today as archival documents; I will discuss the continued "work" of the archival LPH records later in the dissertation.

The amalgamation of bureaucratic and medical information within single acts of recordkeeping and specific documents is especially evident in an example from a 1955 State Board discussion about the recordkeeping practices of a homestead for mentally defective children and epileptics. The initial shift from institutionalization to community care was occurring during this time, and the Board had difficulty managing the community facilities. The Board gave licenses to these facilities, which were often people's private homes converted into homesteads, and continued to be responsible for the patients transferred there. In addition to surprise inspections by Board members, recordkeeping requirements allowed the Board to exercise its power during times of deinstitutionalization and dispersions of patients. In this case, the Board was attempting to evaluate whether the woman who owned the home and her staff were adequately caring for the children:

> [The Commissioner] said any properly conducted instituion [sic] would have records. An attempt has been made to help her as to records but she has nothing in the way of records that we could find. This is a requirement, and we even sent our people up there to help her set up the records but her attitude seems to be that she did not feel she should be concerned with records as to medication, etc.

As a state-licensed residence, the homestead was supposed to meet the Board's personnel and records requirements. These policies had not always been in place, though, as indicated by one board member who noted that the homestead's proprietor was "of the old school as to that sort of thing, and he could appreciate the problem of the red tape involved." This particular board member was sympathetic toward the woman because of what he implied was unnecessary bureaucratic paperwork. At the meeting, the Commissioner countered by saying that "it was not a matter of red tape – there should be records to show who was there, the medication they are receiving, and that sort of thing." The homestead owner claimed to have created some records, including a roster of the patients in her facility and who is receiving medication. However, the Commissioner admonished her for not having "the proper records." These "proper," or what the Director of Psychiatric Nursing also called "certain types," of records included charts that indicated what medications were being given to particular patients.

Understandably from the administrative perspective, the Board wanted the homestead to keep detailed care records in order for the Board to avoid receiving blame for potential misconduct at the community facility. The Director of Psychiatric Nursing was greatly concerned that the homestead staff members were not accurately monitoring the residents. The homestead owner said that she "would try to keep better records," to which the nurse replied that "it would be necessary for [the homestead owner] not only to try but to comply with this requirement in regard to records." The nurse's use of words such as "necessary," "comply," and "requirement" emphasized the increasingly standardized record forms and information requirements for state health care facilities, regardless of the facility's size or history of care. In addition to protecting the Board's public reputation and standing within the state government, the keeping of more thorough records by homesteads could force the homestead owners to take better care of their charges.

Next, I present a specific example from the State Board meeting minutes that demonstrates how hospital records and the changes made to them can continue to have an influence on patients' lives and mediate the relationships between the hospital and its patients, even after individuals have been released from the facility. In 1970, the Board discussed what should be included in discharge certificates, which were given to patients when they were released from the hospital, and who should receive copies of them. Prior to the board discussion, the certificates provided one of two reasons why the individual was released: "The Statutes previously provided that upon discharge of a mentally ill patient he be given a copy of the Discharge Certificate on which the reason for discharge could be given as 'Recovered' or 'Improved.'" The revised statute reflects the overcrowding occurring at the hospitals, and the hospitals' efforts to evaluate patients in a manner commiserate with deinstitutionalization policies: "The form has been amended to provide on the Certificate the condition of discharge as being 'Recovered', 'Not Mentally Ill', 'Not Recovered but his discharge, in the opinion of the Superintendent, will not be detrimental to the public welfare or injurious to himself.'" The new category of "not mentally ill" points to the state facilities' reexamination of who they have institutionalized and for what reasons. By reassessing long-term patients who were classified as mentally disabled, elderly, or suffered from diseases such as tuberculosis and syphilis, mental facilities were then able to transfer or discharge patients who were not mentally ill but might still have required long-term care. While it was once medically acceptable and fiscally feasible for all of these types of patients, along with the mentally ill, to live together in the hospitals, the Board and the central office were moving in a new direction of smaller, community-based facilities that cared for specific types of patients.

The third new category on the discharge certificates proved to be more problematic than the first two categories for the state hospitals. The minutes state, "Some hospitals have been issuing it without completing all of the statement, and some have continued giving a copy to the discharged patients. Some patients have resented the 'Not Recovered' statement on the Certificate." It is not noted why some hospitals have been

using the abbreviated category, but one can infer that it may have been due to lack of space on the form itself, time limitations of the staff members creating the record, or simply a lack of awareness among the staff members regarding the lengthy category name. It is apparent that the record creators did not realize the effect that their in situ brevity would have on the patients and their relationships with the hospitals.

The LPH superintendent notes in the minutes that, at his institution, rather than changing the recordkeeping practices applied to the original discharge form, they have developed a second document in order to alleviate the problem: "They give the patient a form made up by the hospital." While some board members questioned the necessity of providing certificates to discharged patients at all ("There is no requirement that the mentally deficient patient be given such a statement"), others pointed out that the document could be useful for former patients deemed mentally deficient who are seeking driver's licenses or jobs. Furthermore, as one doctors asked rhetorically, "How about the patient who is committed as mentally retarded and they find that he is not mentally retarded?" The discharge record could make a substantive difference to the individual in terms of his independence and quality of life outside of the hospital.

Following the Board's discussion about the impact the certificate has on discharged patients, they talked about changes to the recordkeeping practice itself. One member suggested, "We follow the code by preparing the official certificate exactly within the terms of the Code, and any other certificate the hospital wants to give the patient be something separate." The provisional separation of the "official certificate" and the one provided by the hospital, such as the one developed at LPH, suggests that the former is part of a larger bureaucratic recordkeeping system that cannot be easily altered. Meanwhile, the latter record, if created at all, is the one that will belong to the patient and have the more immediate and direct impact on him; its production remained the discretion of each superintendent:

> The Commissioner said that in the interim until we have a chance to iron this out completely he would have no objection to what the hospitals want to give the patients, but he would suggest great care about certificates

> reading ‘Not Recovered’. The Chairman felt that this matter should have further study, and directed the Commissioner to consult further with the Superintendents and try to arrive at a satisfactory solution.

This example from the minutes demonstrates that seemingly mundane administrative paperwork can have consequences for patients that are unintended by the Board and hospital personnel. Once hospital personnel classify patients in records, the documents maintain the particular social categories, e.g., “not recovered,” applied to institutionalized individuals. Records, as in the next example, also support institutional decisions such as irreversible medical operations.

Like other mental institutions during the Progressive era, LPH performed psychosurgeries, shock treatments, and sterilizations. While lobotomies and shock treatment are not discussed in any of the archival records that I examined, mentions of sterilizations appear frequently in the minutes, most likely because of the legislative (as opposed to psychiatric) underpinnings of the sterilization movement, which made the operations a state bureaucracy matter as well as a medical one. The first recorded mention of sterilizations in my dataset occurred in the 1928 LPH Board minutes: “That twelve cases suitable for sterilization had been selected and the proper forms prepared arranging to legal requirements and petitions in these cases would be presented to this Board at its next regular meeting on August 13th, 1928.” The new hospital practice to perform sterilizations on men and women corresponded with a state law that required the sterilization of individuals considered feebleminded. In August 1928, twelve women were listed in the minutes as having come before the Board for a hearing regarding their petitions for sterilization. The LPH Superintendent was also present, as well as a guardian ad litem for the patients. Along with the names of the patients presented before the Board, it was often noted how much the doctor who performed the sterilizations was being compensated for his services. The minutes note that each patient was heard by the Board, “after which the order for sterilization of each case was entered.” When the cases for sterilization were presented, the same language was used each time: “All of the papers

in the above cases were ordered filed as a part of the records of this Board." Once the papers were filed as part of the Board's records, the orders for sterilization were final and cemented those patients' fates.

Sterilizations continued throughout the second era as evidenced by the minutes that I examined. The Board heard the cases on a monthly basis, and on rare occasions, patients "did not consent to the operation and their cases were dropped." Based on the minutes alone, it is difficult to surmise how the Board interpreted consent, especially given that the hospital deemed these patients mentally disabled and potentially incapable of giving their permission. In September 1936, one woman stated she "was not willing and desirous that the operation for sterilization be performed upon her." To support her claims, her mother and a reverend were also heard by the Board. The Board then informed them that the state law governing sterilizations gave the patient and her family thirty days to appeal to the circuit court the order for sterilization. It is unknown if the patient was able to make a successful petition.

In the 1955-1970 era, the State Board minutes lists for all of the state facilities the names of the patients who were approved for sterilizations or had the operation performed on them. The number of approved operations for LPH was markedly lower than in the previous era, which can be attributed to several factors, including limited state funding for the surgeries, a decline in the popularity of the procedure, and an unavoidable focus on custodial care rather than treatment due to low staffing and patient overcrowding. August 1964 marks the end of listing sterilization patients in the State Board minutes. However, the operations were still occurring as evidenced by the board members being assigned to the hospital sterilization committees well into the late 1960s. By this time, revised courses of care for the mentally disabled were being implemented, such as vocational training and community care. In 1974, the eugenics-based sterilization law was repealed.

The act of systematically recording sterilization cases in the minutes for nearly four decades allowed both the LPH Board and the State Board to acknowledge publicly

their decisions and to gain a sense of measured governance through documentation. Once the Board was no longer discussing sterilization cases at their meetings, the minutes reflect through absence what the Board no longer controlled and was willing to be held responsible for. Notably, lengthy stories and descriptions of hospital incidents were also no longer included in the minutes. The lack of specific information regarding the incidents and patients' names speaks to the state's protection of both their patients' identities and their institutions. Arguably, having thorough records became a legal risk for the Board. As an unintended consequence, researchers such as myself lose insight into the decision-making processes and actions that take place at the hospitals, but gain an understanding of the mental health division's growing aversion to risk.

Some individuals institutionalized at LPH were subject to medical procedures that were considered to be the best treatment options at the time, but are now widely viewed as controversial. The intentional and unauthorized mistreatment of patients by hospital personnel, however, was always condemned by the Superintendent and Board, albeit with varying degrees of punitive action being taken. The predominant problem was staff members using their roles as caretakers to assault patients. The earliest LPH Board minutes give us insight into the types of personnel-patient problems that the Superintendent and the Board were in charge of addressing. The representations of specific patients in the minutes are limited at best, in that any information regarding the patient is purely to help investigate the case. We must remember that, in these cases, the minutes primarily served the Board as evidence of the deliberations to determine if any employees were guilty and, if so, what was his punishment.

The language used for the minutes in cases of violence against patients tends to be formal and euphemistic throughout the hospital's history. For instance, in the May 1873 minutes, it is written, "Two men & two women have been employed to keep watch in the female ward. One man & one woman being always on watch together. By this arrangement we hope to prevent all irregularities." The "irregularities" are the rash of

pregnancies among patients likely caused by attendants. A patient's pregnancy was discussed in February 1926:

> A careful investigation had been made but no definite evidence as to guilty party could be gotten as the patient was quiet, kept her fingers in her mouth, grinned and refused to answer questions. […] there was not sufficient evidence to make an arrest […] [The Superintendent] cautioned all nurses and attendants in that department to keep a close watch on the patients when male employees or patients were working therein. On motion of Dr. [redacted], the Superintendent was directed to make a report of the case to the nearest relative of the patient and to the [state]'s Attorney of [redacted] County.

Those who were victims of sexual assaults within the hospital often were unable to give the Board definitive evidence of the culprits as seen above with the female patient who supposedly "refused to answer questions." The minutes imply that the woman was capable of answering the investigators' questions and willfully declined. For these patients who lacked agency – and there were many at LPH – they depended on the Board to help prevent further bodily harm by hospital staff members. The usual courses of action in the late-19th and early-20th centuries tended to be provisional solutions, such as the hiring of more female employees and increasing surveillance of attendants, rather than addressing the systemic power imbalances and violence. Furthermore, the preventive measures did not always occur; in 1872, the Board considered the possibility of having all-female staffing at night in the women's ward, but the Superintendent "replied that a part of the work [e.g., laundering] was heavy for the women." The Board decided that male attendants must continue working in the ward so as not to disrupt the housekeeping schedule that the hospital administration had become accustomed to.

The minutes illustrate a long history of the Board taking action to address violent incidents at the hospital while also striving to maintain hospital operations. Unusual or violent deaths among the patients were discussed at meetings. Nearly all of the Board's investigations regarding patients' deaths recorded in the meeting minutes that I examined concluded with the hospital and its staff members being deemed not at fault, and the

coroner or county attorney providing a written statement or certificate that said he found "nothing in the circumstances attaching any blame on the hospital or its employees." Daily logs and case file records were used on occasion for testimonial purposes when patients' deaths were under investigation, as in the case of a female patient who died in 1925. The patient's mother accused the hospital administration of lying to her about the poor conditions of the facility and care for her daughter. Doctors and attendants gave statements under oath, and records were examined to provide evidence that the patient had been "a highly excitable person who was very disruptive" and prone to burning herself on the radiator pipes (which were covered only in the epileptic wards at the time) despite attempts to keep her "locked in her room during the night and sometimes during the day." In addition to shifting the fault for the patient's death back onto the patient, the doctors also claimed that the she had trouble eating and, when the mother fed her solid foods during her visits, it "probably hastened her death." The staff insinuated the mother's culpability further by noting that a personal attendant could have been possible if "paid for by the friends of the patient." Both the mother and daughter, according to the staff, were conducting unsanctioned activities in the hospital and, in doing so, led to the patient's death.

Whether the subject of legal investigations or medical studies, the bodies of patients are on display in the written LPH records. Throughout the three eras that I examined, their bodies were recorded both in life and in death in the registers and the minutes. The mother of the deceased patient from the 1925 case vividly described her daughter while alive as being in "miserable condition," including being undernourished, "clad in soiled rags," and having "bruises and scars over her entire body and open sores on her wrists and legs which appeared not to have been promptly dressed." Most accounts of patients' bodies, especially as given by the Superintendent, are not as descriptive. In the first era, the LPH Superintendent always reported the causes of patients' deaths for to the Board each month. For example, in September 1880, the Superintendent reports,

> A much larger number of deaths occurred this month than is usual, owing to the fact that two of the patients recently received were in extremely low condition when they arrived. One lived less than 24 hours after arriving and the other about 10 or 12 days. The cause of death in the other 4 was from congestion of the brain, old age, Dysentry + Epilepsy.

While we cannot know with certainty the exact wording used by the Superintendent in these early meetings, the minutes tend to contain language that emphasizes how the patients arrived in "extremely low condition" or were old and feeble. In addition to providing the reasons for the patients' deaths and freeing the hospital from responsibility for them, the reports also highlight LPH's increased interest in post-mortem examinations. Autopsies conducted at LPH served dual purposes: to provide medical evidence that the patients died of natural causes and to be included as part of the hospital's research agenda. In June 1881, the LPH Superintendent gave a report to the Board on a deceased patient with unusual physical characteristics:

> The death reported was caused by consumption. The man if you recollect, was a very tall homicidal maniac, with a head of unusual dimensions. A post mortem examination was made. The brain had a healthy appearance. The membrane somewhat thickened. The weight of the brain was most remarkable. It weighted 5 ounces more than any brain yet recorded. The weight was 70 ounces. The largest brain heretofore recorded was that of Cuvier the famous French anatomist and naturalist. His brain weighed 65 ounces. Daniel Webster's brain weighs 64 ounces.

The Superintendent's digression into brain anomalies points to the developing field of psychiatry. At the time, state facilities such as LPH were actively participating in research to better understand the physiology of the bodies, and especially the brains, of the mentally ill and mentally disabled. Studies by LPH doctors would disappear especially by the mid-20th century when state hospitals were struggling to keep up with

their large patient populations; the bodies of some LPH patients were nonetheless still studied by students from nearby medical colleges.[54]

The Board and Superintendent occasionally discussed matters relating to deceased patients' bodies, from autopsy reports to undertakers' fees. In 1876, the need for a "dead-house and dissecting room" and the purchase of the related necessary instruments and microscope was brought up. In 1926, after receiving a complaint from a patient's widow, the Board looked into purchasing or building an ice box to better maintain corpses awaiting burial during the summer months. Not all patients' bodies were buried at the LPH cemetery or returned to their home towns, however. A state house bill from 1928 was brought to the general board for all the mental facilities in the state to determine if they should allow medical colleges to use deceased patients as cadavers for study. Then in 1929, the Superintendent's hospital department operations monthly report, states, "Special attention was called to the number of autopsies, which showed that for the past month, the hospital had done 100%." Surviving records of where deceased patients were buried are sparse. Other than very early mentions in the minutes regarding another cemetery that was used prior to the move to LPH's current location and of fees for an undertaker, the final resting place for most of the patients is unknown. Some bodies were shipped to their families, some were used for medical training, and some were buried in the hospital's cemetery. The non-modern grave markers in the cemetery are constructed of inexpensive rebar and concrete engraved with numbers (see Illustration 11) – unfortunately, I did not find any records that connected the numbers with individual patients. Many of the markers have also weathered to the point of being unreadable.

[54] In order to boost the number of potential doctors and nurses at LPH in the 1960s when the state hospital was struggling to fill medical positions, the administration developed a residency training program and a nursing affiliation program, respectively.

Illustration 11: Grave marker in LPH cemetery. Image: the author.

The LPH cemetery is relatively small, especially when considering the thousands of individuals that were institutionalized at LPH and died there. It remains a mystery where many of the bodies went. When discussing the lack of marked burial sites, Dennis H. muses,

> You look at the annual reports where they talk about admissions, discharges, and deaths. And even though numbers may be small and then sometimes through influenza, numbers would get to be big. But then you multiply that times 150 years, that's a lot of people. And I can't find them anywhere out there. […] Yeah, it's an interesting place. I mean, what's written and what's not written.

Some staff members speculate that there are unmarked grave sites located in other parts of the LPH campus. In 1991, the state's mental health department formally acknowledged its predecessors' lack of recordkeeping regarding the bodies of decedent patients when it

erected a small monument in the hospital's cemetery that is "in remembrance of those persons who were served and buried in the campus cemetery during the early years and are known only to God. May they rest in peace." The stone stele created by the central office to commemorate the dead at LPH is one way to remember those who have died at the hospital. Another way is through the remaining archival hospital records, which have the potential to be used to help shape or entirely govern the identities of formerly institutionalized individuals. However, in this lengthy discussion section on accountability and power through recordkeeping, I have shown that the records tell us as much about the hospital and its practices (if not information about the specific record creators) as it does about the decedent patients.

In this section, I have demonstrated through examples from my dataset that patient-related documents are social constructions made for the benefit of the medical personnel and hospital administration. The identities and lives of patients briefly seen in the registers and minutes, as well as more fully in the case files, are mediated by the record formats and the specific needs of the hospital at the time. These records have been integral to the successful functioning of LPH over a one hundred-year period, whether to better treat patients or to stay accountable to superiors, and often times both. Records were used to monitor both patients and staff members, albeit in different ways. While members of the staff were overtly held responsible by their supervisors for their actions by means of bureaucratic recordkeeping practices, patients were being surveyed and controlled through the records about them. Hospital records ensured that institutionalized individuals were identified by social categories regarding their bodies and minds, and treated as such in LPH and even outside the hospital environment.

Records as objects hold a great deal of political, social, and financial power. Besides the potentially influential recorded information that they bear, the physical documents can also hold and convey authority that goes beyond spoken words or a person's lifetime. Therefore, the records, and the information that they carry, have never moved freely around the hospital or been shared publicly without careful consideration

by the institution's administrators. As I observed, the records' movements over time became increasingly restricted according to stratified and regulated workflows. The archival records from LPH can continue to inform, albeit in ways that were not foreseen by the documents' creators. The next section will focus on an aspect of LPH that is relatively unacknowledged in the records, although it is perhaps its most prominent feature: its African American roots, which continues to affect the hospital's interpersonal and organizational relationships today and the preservation of and access to the archival records.

THE ENDURING IMPACT OF RACE

LPH has been entrenched in racial politics from its inception, and its social ecologies, including that of its archival records, continue to be informed by the hegemonic race relations from the hospital's past. The hospital emerged from the public welfare concerns of a group of African American and Caucasian politicians working together immediately after the Civil War to provide social services to newly freed Blacks. Without their advocacy, there might not have been any reliable mental health care available to emancipated slaves.

After several years of searching and negotiation by the hospital board for a suitable piece of land, LPH was relocated to a permanent site in 1885, adjacent to a bustling city that was predominantly African American and a seat of political power in the state during Reconstruction. This city's political stature and its idealistic cooperation among Blacks and Whites, however, could not withstand Jim Crow-era "separate but equal" state laws, especially after segregation became federally supported by the 1896 *Plessy v. Ferguson* decision. Like the faltering efforts of the Freedmens' Bureau, the politicians who spearheaded the creation of LPH were unable to fully realize lasting equal opportunities and services to African Americans in the face of strong regional and federal resistance. Dennis H. told me during his interview, "They had power for about 15 years and that was the power of [town near LPH] that the real heads were here and we

had the iron industry and some other stuff and this was 1860, ’70, ’80. And then Reconstruction came and things kind of fell over.”

In the first era of board meeting minutes from my dataset, 1870-1885, I found two separate incidents involving African American staff members that highlight early attempts at racial integration within the hospital administration. These minutes suggest that LPH was unlike the other state hospitals, which had emerged out of regional need rather than a racially motivated one. While LPH was populated entirely with patients classified as non-White, the early hospital board membership reflects attempts by LPH administration to have a racially integrated board and staff. These early efforts were at once idealistic and hastily conceived, and were more indicative of tokenism than equal hiring practices. They also illustrate the eventual settling into de jure and de facto racial segregation and hierarchies.

The first incident appears in the minutes in November 1870, in which an African American board member and director of LPH was accused of attempting to collect bribes from candidates vying for job positions such as steward and superintendent at the hospital. Several of those candidates came forward and testified in front of a magistrate that the board member tried to extort money from them. The meeting minutes then state:

> The description here ended & it was decided to take the sense of the Board as to the guilt or innocence of [the accused]. But before this was done [another board member] rose & said that it was a matter exceedingly to be regretted that [the accused] had proved himself unworthy of the trust conferred to him by the Governor of the State especially as it was the first instance in which persons of his color had been appointed to similar responsible positions in the State by the executive. At the conclusion of [the board member’s] remarks, the Clerk was ordered to call the vote. Each member as his name was called voting Guilty.

The regretful board member’s statement is indicative of the state-wide effort to place African Americans in “responsible positions.” His wording also suggests that the accused and other “persons of his color” were being tested to see if they could be relied upon by the state and country that had allowed their enslavement. The Board encouraged the

accused member to resign after the guilty vote. While at least one other subsequent board member would be African American during this early era of the hospital's history, this incident is a sign of the tenuous and sometimes strained relationships between Blacks and Whites as they negotiated daily, institutional life after a war based in large part on conflict about the legitimacy of slavery.

In the second incident, LPH's first matron allegedly was failing to meet the requirements of her job and for general "unfaithfulness" to the institution. At the first hearing in April 1872, the Superintendent said he wished to fire her "upon the ground that her presence was a hindrance to the administration of the affairs of the Institution, and in fact was a positive nuisance." During the matron's first appearance before the Board, she presented a written statement that was copied verbatim into the meeting minutes. In her own words, she expressed her frustration with working with White staff members who disregard her because she is Black: "it cant be any order in here whenever i give any reports since of the attendants says that the white people say they Dont want you to give any orders in the ward." Her poor Standard English writing and language ability probably put her at a disadvantage when trying to defend herself in front of the Board that appeared to be governed by formality and propriety. During her second meeting with the hospital board in May 1872, the matron had counsel. She presented another written statement that differs greatly from her first; the language is now in the style of the board members' own language:

> During the absence of the Superintendent the Patients were treated with great cruelty by some of the attendants, which I could not report in consequence of the order referred to. Several colored members of the Legislature, while on a visit of inspection to the Asylum, questioned me about the reports which had reached them of the cruel treatment and exposure & suffering of the Patients, and I was forced reluctantly to confess that they had been correctly informed.

Her lawyer then protested in writing that he did not have adequate time to prepare for the case, but the matron was nevertheless fired for inefficiency and subordination.

Nearly a year later, in March 1873, the Superintendent informed the Board of "engaging a suitable colored matron for the Asylum." A month later, the minutes reported:

> The question of possibility of [inserted: finding] a colored woman possessed of all the qualifications necessary for this important office was discussed, & the conclusion unanimously arrived at that it was impossible. And as this question had been freely discussed at previous meetings with the same result, it being concluded at all times that it would be best to have a colored matron if practical. It was therefore unanimously Resolved That the Superintendent shall immediately [inserted: proceed] to find a middle-aged [inserted: white] woman of good character & standing, who would accept the offer, & having found such a one, to engage her for one month in trial.

It is unclear from the minutes why the Board again sought out an African American woman for the position. I suspect that the hospital's doctors and the Board assumed that the female patients would place confidence and trust in someone who looked like them, reminded them of a family member or friend, or they may have personally known. As I pointed out in the section on accountability, descriptions of the Board's discussion in the minutes was for the members' own benefit in case their decisions were challenged in the future by a new board or the Governor. Therefore, by having in the minutes that the Board made a good faith effort to search for a Black woman to be matron, the Board could not be criticized for hiring a White woman by state officials who might have insisted some of the hospital's staff positions be held by African Americans.

During the first era of recordkeeping at LPH, other instances of characterizing individuals by their African American ethnicity appear in the records. Recall that at this time in U.S. psychiatry, doctors such as Samuel Cartwright were convinced that Blacks were genetically predisposed to suffer from mental illnesses differently than were Whites (Gibson and Denby, 2007). In Henry A.'s social history research examining the differences in 19th-century diagnoses of Black and White patients at St. Elizabeths, he found that the former were identified predominantly as having mania, followed by dementia. Meanwhile, the latter were diagnosed primarily with mania and melancholia.

While it can only be inferred that the St. Elizabeths' doctors thought Blacks were perhaps unable or less likely to suffer from melancholia, it is clear that psychiatrists in the U.S. and especially the South were interested in recording physical and mental characteristics supposedly rooted in race.

My findings in the LPH patient registers suggest that, although all of the admitted patients to LPH were classified as Black, variations within "Blackness" mattered to the medical staff members enough for them to make note of it. In the 1882 LPH patient register, there is an entry for patient 1108, who was a female admitted to the hospital at the age of 18. Although there is no formal category for race in this particular register, it is noted after her name that she is "(mulatto)" (see Illustration 12). Similarly, a male servant admitted in the same year at the age of 20 is also described as being mulatto in parenthesis. This description of mixed race is inserted as if almost an afterthought, an anomalous characteristic that is thought to be possibly worthwhile to record. And yet, just as the word "mulatto" follows the individual's name, it is a textual shadow or social marker that haunts these individuals – the only two defined as such in this register – throughout their confinements. For the 18 years that patient 1108 resided at LPH, she was a mulatto both in the only record that marks her existence at the asylum and as perceived by those that interacted with her in the asylum. The register record, of course, continues today to delineate her as different from the other individuals admitted to LPH in that era.

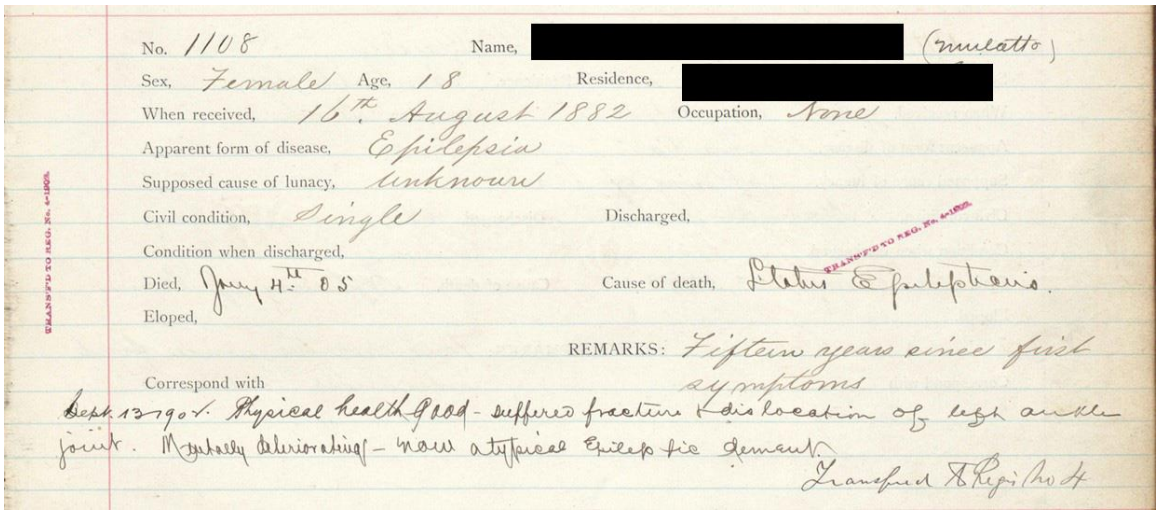
No. 1108 Name, [redacted] (mulatto)
Sex, Female Age, 18 Residence, [redacted]
When received, 16th August 1882 Occupation, None
Apparent form of disease, Epilepsia
Supposed cause of lunacy, Unknown
Civil condition, Single Discharged,
Condition when discharged,
Died, June 4th 05 Cause of death, Status Epilepticus.
Eloped,
REMARKS: Fifteen years since first symptoms
Correspond with
Sept. 13 1904. Physical health Good - suffered fracture & dislocation of left ankle joint. Mentally deteriorating - more atypical Epileptic demand.
Transferred to Rep. No. 4

Illustration 12: LPH register entry (1866-1887) for patient described as "mulatto," c. 1882. Digital redactions by author/Image: LPH Archives.

The complexity of an individual's racial identity persisted in troubling not just the administrators at LPH, but also the entire Jim Crow South. The governments of the Southern states were determined to differentiate between White and Black individuals, and in order to address any particular ambiguity, several states adopted "one-drop rule" laws. These laws deemed an individual with any perceived African ancestry to be labeled as "colored." LPH is located in a state whose legislature in the early 1920s passed an anti-miscegenation law to uphold the so-called integrity, or separation, of the races. The state law emerged from a time in which the South was becoming increasingly concerned about legally maintaining physical and social separation of Whites and non-Whites in all aspects of daily life – in public places, at work, and in the home.

LPH was an exceptional state facility during the 1925-1940 period, in that Blacks and Whites had to interact, whether among patients and doctors or among staff members. The interactions were mediated by the hierarchy of personnel, though, as board members and administrators were White while their lower ranking staff members, e.g., attendants, were African American. In the archival records, there is little documentary evidence of the racial makeup of the LPH staff at this time, but historical context suggests a hegemonic structure based in part on race. In the July 1926 meeting minutes, there is a

brief item regarding the registration of state officers and salaried employees, and the record notes "there are 25 white officers and employees, 2 traveling agents, 153 nurses and attendants and 29 other employees in the service of the hospital." It could be inferred that there are only 25 White staff members of 209 workers at LPH, and they all hold supervisory positions. I have also inferred from the 1955-1970 minutes that efforts were made prior to the Civil Rights Act of 1964 to keep staff members of different races as physically separate as possible, in the form of different eating spaces, restrooms, and so forth.

While LPH's African American members of the staff were likely given poorer facilities and faced other forms of social and economic discriminations within the confines of the hospital, the other state hospitals appear to have looked upon LPH's White administration with some sympathy and perhaps even haughtiness because of the hospital's all-Black clientele. While it is difficult to speculate without seeing the financial records from the other mental hospitals in the state during the second era whether the state government gave less funding to LPH per patient than the other facilities, it is highly unlikely LPH received proportionally more funding or had more staff members than the all-White mental institutions. In a 1934 LPH board resolution for a popular and longstanding superintendent who recently died, it is written: "While superintendent of [LPH] he was offered the superintendency of other hospitals, including that of one of the [state] hospitals for the white insane. All of which he declined, to remain where he had first put his hand to the plan." To work at LPH was considered a charitable endeavor, even a higher calling, more so than working at a mental institution for Whites.

Race discrimination laws and prejudicial attitudes toward social services for Blacks reinforced a two-tiered socio-economic system. One way this far-reaching and often unspoken inequality manifested itself in the records can be seen in the 1925 minutes in an interaction between the superintendent of LPH and that of another state hospital, one of the three all-White mental facilities in the state at the time. The incident involved a woman committed to LPH in March 1924, but then transferred to the other institution in

July 1924 because the LPH superintendent viewed her as being White. In August 1924, the superintendent of the all-White facility wrote to say that his hospital was severely overcrowded and the patient would only be allowed a cot and her transportation costs would have be paid by LPH or the woman's friends. The financial matter continued to go unresolved. Then in a January 1925 meeting of the LPH Board of Directors, along with the news that fourteen hams were stolen from the hospital, the Superintendent announced that the other institute had not sent a refund for the female patient's transfer cost: "That refund of $18.81 for transferring [name of patient], a white woman, to the [all-White state hospital] had not been paid by that institution in accordance with request of the Board on August 13th, 1924."

The following month, along with the news that a new tractor and mules were to be purchased, the LPH Board learned of the response from the superintendent of the all-White state hospital:

> My dear Dr. [LPH superintendent]: Your letter received in regard to the bill for bringing Miss [patient] to this hospital. Our Board decided not to pay this. Personally I think she is a negro, and some of our patients object to being with her on that account.

The epistolary dialogue between the two superintendents and the transfer of the female patient demonstrate how an individual's race can come under dispute. The superintendent of the White hospital's response, "Personally I think she is a negro," is tentative, but not because he viewed racial classification as a social construct. Rather, the doctor's language of estimation came from not being able to undisputedly prove that the patient has African ancestors. The superintendent further supported his suspicion of the woman being "negro" by noting that his patients also believed she was Black. The apparent disturbance she caused among these patients was yet another reason for him to deem the woman as being wrongly classified and placed at the White hospital.

The alleged misidentification of the patient's race implicitly served as justification for the all-White facility to place the fiscal burden, albeit a relatively minor one, on LPH. Since the LPH superintendent purportedly misidentified the patient's race, his institution

should pay for patient's transportation expenses. At the February 1925 meeting, the LPH Board decided to cancel the refund request, saying, "That in view of the fact that it is a question between two State institutions for the insane involving a small amount that the matter be dropped." Typical of issues regarding patients that are found in the minutes, while the Board settled the financial matters at hand, it remains unstated what happened to the patient. Presumably, the patient remained at the all-White facility as an outcast, stigmatized for being Black. The racial classification applied to her by White male doctors, members of at least three dominant social groups, affected how she was treated by others, medically and socially.

During the same period of time that the State Board secretary recorded the superintendents' negotiations regarding a female patient's racial identity and transfer costs, a formal category for designating the skin color of admitted patients was part of the LPH register. The preprinted category of "color" not seen in the register from the 1870-1885 period and the mutable schemata used in the register during the 1925-1940 period reflect changing social constructs for race. In his discussion of the early-20th-century cancer researchers, Wailoo (2011) notes that, while they were convinced of the importance of race in determining cancer rates, "what they meant by 'race,' however, kept changing," and thus invalidating any attempt to find a "single epidemiological truth" over time (p. 6). Similarly, the reasons for changes in the recorded descriptions of race or skin color at LPH may have been motivated far more by structural socio-legal norms than is indicated by the medical records' façade of objectivity. The schema to describe the color of patients in the LPH register changed in the late 1920s, possibly because of the one-drop law and the increased focus on separating Blacks and Whites. Prior to 1927, patients were described in the registers as either "Brown," "Black," or "Mulatto." In a March 21, 2013, journal entry, I reflect on how language for skin color is a culturally and temporally mediated construct:

> The use of "B," "Br," and "Mul" for "Color" is fascinating. It's a strange mix of racial descriptors and literal skin color descriptors. I should look into seeing if it was common to describe lighter skinned African

> Americans (but were not considered mixed race) as "brown." In my experience, the use of describing a person as "brown" has tended to come out of the postcolonial movement in which people of color self-identify as "brown." Using that description works as a way to describe a wide swath of people who have been seen as the "Other" or non-White.

Beginning in the 1927 registers, the possible descriptors for skin color grew to include "Black," "Brown," "M" or "Mul" for "mulatto," "C" or "Col" for "colored," "Yellow," "Light," and "Dark" (see Illustration 13). It remains frustratingly unclear why a formal skin color category was added to the registers. Since it was a prerequisite that any person admitted to LPH be African American, I can infer that these skin color descriptions were not a legal requirement, but was perhaps a legal precaution. Was the category added for administrative recordkeeping purposes in case there were disputes, as there was over the transferred female patient, over a patient's race? Or was the category included so the hospital or state could produce demographic reports? Or perhaps it was part of a medical research effort to relate mental illness and disability with race? Those are the kinds of questions that a scholar of African American history or history of medicine could begin to address by looking at other records from the time period, such as admission registers from other state hospitals, medical journal articles, and legislative hearings.

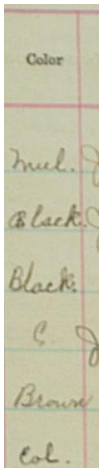

Illustration 13: Detail of "Color" category in LPH register (1871-1933), c. 1927. Image: LPH Archives.

In the third and last era of LPH records that I examined, 1955-1970, incidents and decisions related to race continued to be part of the board meetings discussion. The notion of separate facilities for Black and White staff was a well-established, normative practice by this time. At a meeting of the LPH building committee in June 1956, the committee discussed the remodeling and new equipment necessary for new cafeteria facilities:

> Attendant and Nursing Personnel, for colored employees, would remain in the same location as at present, with remodeling and changes that may be needed, and to which will be added at the north end of the building, in two rooms, which are now vacant, a kitchen and dishwashing equipment. White employees, including all types, would be served in the [cottage] on both the first and second floors. This would be done by eliminating the kitchen and moving, from [large ward], the cafeteria equipment in use their [sic] in the employee's dining room.

This account highlights how the state's "separate but equal" laws were financial and logistical burdens to LPH, probably more so than at the other state hospitals which may not have employed many, if any, African Americans.

In the years leading to the Civil Rights Act of 1964 and the eventual desegregation of state facilities, actions and relationships at LPH from individuals up to institutions were influenced unavoidably by a culture of racial discrimination and prejudices that was both socially and legally acceptable at the time. In February 1956, "the Commissioner stated that attempts had been made to find a qualified white person to head up the Social Service Department at Larch Point Hospital but they could not find anybody who would accept it." This problem speaks to the acceptable bias toward hiring Whites over Blacks for supervisory positions. The difficulty of finding a White person who would accept the position at a hospital for Black patients also indicates the local attitudes toward LPH and the ongoing challenge the hospital faced in finding qualified doctors, nurses, and other supervisory staff members.

At the same meeting, the Commissioner said that the Superintendent interviewed a Black woman "who meets the qualifications and is very highly recommended," and

hired her. According to the Commissioner, a White woman "who has been employed at the hospital for a number of years as a Social Worker Aide, has become very much concerned over the employment of a colored person as Supervisor of the Social Work Department." In an accommodation that would be rare today in the U.S., the hospital devised a way that the aide would not have to interact with the new head of Social Services: "arrangements have been made for [the aide] to continue the work which she has been doing under the supervision of the Superintendent and the Clinical Director, and she would not be supervised in any way by this colored Social Worker." The aide's problem with the new social work supervisor appears to not be that of Whites and Blacks interacting, but that she would be overseen by a Black woman, indicating the socially acceptable racism of the time in the workplace. While the State Board initially said they would investigate the situation further, in a display of the closed door power of the Executive Board, the Board decided to approve the hiring of the Black woman and announced succinctly: "the employment of the colored Social Worker was authorized." One board member, however, voted against the motion. The actions of the Executive Board and that of the LPH Superintendent indicate some progressive thought toward racial equality; despite their first choice not being the Black woman, they at least seem to be advocating that, given the hiring difficulty, a qualified Black person should have the job regardless of how other employees may have felt. It is unknown what happened to either the social worker aide who objected to the hiring or the woman who became a supervisor.

The racial biases documented in the hospital board and state hospital board records are systemic and reach into every aspect of the state mental health system that LPH is part of. In 1933, the minutes record a presentation given by the LPH superintendent to the governor, pleading for more funding during the Great Depression. He stated that the ratio of physicians to patients should be 1:150 and that of nurses and attendants to patients should be 1:8. In the data he provided, he claimed that the average ratio of doctors to patients for all state hospitals in the U.S., was 1:184, but in their state,

was 1:357 and at LPH 1:600. He claimed that the nurses and attendants to patient ratio at LPH was 1:14. In 1933, while LPH had the most doctors of the facilities in the state, it also had the highest patient population and the lowest per capita cost.

A culture of financial restraint permeates the history of LPH administration, which arose out of necessity from the segregated state mental facilities. The 1956 minutes reveal a number of additional and continuing inequalities between the Black and White state mental facilities. They were separate and certainly not equal, as LPH remained the only Black mental hospital and was grossly overcrowded. In October 1956, for example, LPH had 4,500 patients while the other major state facilities had at most 2,500 patients. Just prior to desegregation of the state hospitals, LPH's rated bed capacity was 3,536, with the next highest capacity at 2,127. Similar to the statistics from 1933, although LPH received more total funding from the state, it collected less per capita. As a state facility, LPH received monthly reimbursements per patient and it had the lowest monthly patient reimbursements, both before and after desegregation. Although LPH always had the most patients in the state, its residents and staff only consumed 19% of the beef used by the five major mental health facilities in 1956. Two decades after the state hospitals were desegregated, LPH continued to function with less resources. Interviewees noted that they have perceived in the past purchasing and construction restrictions that were unique in the state to their hospital. One interviewee I spoke with recalled, "So that even when [another state hospital] had computers, [LPH] didn't." Other examples I heard were limitations in what kinds of mobile phones were provided to medical staff and less aesthetically pleasing new buildings. Whether the financial limitations were put in place by the state agency that oversaw mental health care facilities or by the hospital administration itself, LPH continued to be marked by frugality.

Beyond the financial and resource differences between LPH and the other, non-Black hospitals in the state, LPH was also singled out for medical purposes because of its unique minority population. A couple of years after the U.S. Public Health Service had begun performing its infamous syphilis study on African American men at the Tuskegee

Institute, the agency reached out to LPH in November 1934 to conduct "certain research work in connection with diagnose and treatment of syphilis," which the hospital board approved. Typical of these types of inter-organizational arrangements, nothing further was recorded in the minutes about the results of this agreement. Twenty-two years later, in November 1956, the State Board endorsed a proposal from the local medical school, which had applied for a federal grant to train neurosurgeons, psychiatrists, and neurologists in psychiatric and degenerative neurological conditions by having them perform autopsies of patients. According to a doctor from the medical school, LPH was "the best source of this [autopsy] material." The State Board noted that while "there were some problems that would have to be ironed out, such as getting authorization from the families of these cases to perform these autopsies, etc.," it was enthusiastic about participating in the training program. These two instances of LPH agreeing to contribute patient bodies, both alive and dead, to outside organizations illustrate the hospital administration's eagerness to participate within a larger network of medical professionals and especially research groups to advance knowledge about mental diseases. By taking part in medical research, even if only providing the studied subjects, the hospital's administrators could raise their institution's social stature and strengthen organizational ties within its professional network (Starr, 1982). During the 1955-1970 era especially, the hospital struggled to remain relevant in the medical community as psychiatry was turning toward community care and, as noted by a state psychiatrist in June 1970, medical students were attracted to "a trend of social consciousness" and focused on finding programs that were "exciting and stimulating," i.e., what was not being offered at state facilities.

The Civil Rights Act of 1964 had a significant effect on all of the state mental facilities in the South, but the consequences of this legislation are mentioned very little in the minutes. The desegregation of the hospitals in LPH's state occurred during four months in 1967. In January 1965, "the Chairman reported that the Board had authorized the Commissioner to sign the Compliance Pledge in connection with the Civil Rights

Act." Then in December 1966, the Board sent a plan to the U.S. Dept. of Health, Education, and Welfare regarding how they would comply with Title VI of the Act. The desegregation plan was called euphemistically the "regional geographic plan" by the Board and the doctors.

Starting on March 1, 1967, in the patient registers, an unlabeled column was used to indicate that at least one-half to two-thirds of the incoming male and female patients were transfers from another hospital in the state. Their admittance dates indicated that many of the patients had been institutionalized at the other hospital for several years or even decades. One LPH register that covers 1964 to 1967 shows a marked growth in the number of patients from fiscal year 1965-1966 to 1966-1967 with an increase from 1,723 patients to 2,475, respectively, and parallels with the desegregation of the state mental facilities. All of these individuals are listed as "mentally ill," and none appears to be a child, which belies Betty T.'s recollection of the first White patient at LPH: "the first one was a little girl […]. She had blonde hair." As a result of this influx of White patients, the total number of admitted patients through May 1967 was higher than normal.

Cathy R. recalled that, for the African American patients, it was a cultural shift to live with Whites. These patients "went through an adjustment period" during desegregation, and "it took a little time to iron it out. After that bit, they got along." Cathy R. noted that the LPH staff already had members of different races at that time and her relationships with other staff members did not change. Her work, however, became more difficult because of administrative decisions that were not explained to the staff, as seen in her hesitant statement, "It seems as though we got the sicker patients. […] I really don't really know who decided from the other hospital. […] It was supposed to have been going by – they first said demographic, but that didn't last long. But it was – it was an adjustment for all of us." In June 1967, the minutes noted that transfers with two of the other hospitals were happening and almost done, such that the latter was now "25% non-white." By July 1967, the large influx of White patients ceased. Any problems among the desegregated patients were not indicated in the State Board minutes. In December 1967,

however, the LPH superintendent noted that there was a rise in cases admitted for alcoholism since the "geographic plan" went into effect, implying that he observed a larger percentage of White patients diagnosed with alcoholism than he had seen among Black patients.

The notation indicating if a patient was transferred from another state hospital is the only evidence in the register of desegregation until 1969; the formal categories in the register do not denote the patient's race, ethnicity, or skin color. Then on July 1, 1969, an unnamed record creator for the registers denoted an unlabeled informal column. Every patient is designated as "W" or "N," which assumedly stand for "White" or "Negro" (see Illustration 14). None of my interviewees was in charge of the admission registers at this time and could not account for the racial designations. We can speculate, however, why the informal category was created; perhaps it was to collect data regarding patients' races or to help match case files with the admission register entries. The informal category is part of a larger discourse on the persistence of race as a socially constructed category used to identify and sort individuals. The existing archival LPH admission registers and minutes provide some insight into how the prevalent social and biological viewpoints regarding racial differences manifest themselves in bureaucratic business activities across time.

Illustration 14: Detail of informal category for race in LPH register (1967-1977), c. 1969. Image: LPH Archives.

The changing vocabulary for racial classification follows the records into the archives, especially in terms of problematizing the creation and maintenance of a controlled vocabulary for digital searches. On August 3, 2010, during my internship at LPH, I wrote:

> A few thoughts on metadata and race and ethnicity. Today, I continued processing staff photos. As I did this task, I was reminded of conversations I had with Halima regarding the significant properties we should be recording as we go through these photos. It wasn't until we were well into the process of collecting content metadata when we realized that perhaps we should be recording not only the *gender* and *occupational role* of people in the photos, but also their *race*. […] So the question then becomes what should our controlled vocabulary be? White and Black? African American and Caucasian?

These questions of language remain unresolved while the construction of the LPH database and digital archives are still in their early planning stages. I suggest the creation of a glossary, which would provide an overview of the evolving diction choices for key search terms related to race, medicine, and organizational positions. Such a glossary

would be a helpful entry point for users of the LPH digital archives to explore how actors in the hospital realm are discursively represented over time. Contextualizing language, as well as the types of procedures and decisions carried out at the hospital, can illustrate how much has changed in the past 150 years. In conjunction with contextualization, the archival records can help carry on the conversation about how we talk about race as a society and help us better understand our current racial climate.

The personnel at LPH continue to feel the repercussions of a hospital and a nation that was segregated less than 50 years ago. I asked Janet S. if she encountered challenges as an administrator in balancing the responsibilities of overseeing an active hospital with the potential to share the hospital's rich but potentially inflammatory heritage with the public. In response, Janet S. acknowledged that, for some people, whether members of the public or hospital personnel, LPH today will always be tied intrinsically with its past. Janet S. hoped, however, that for these individuals that they can at least apply social and political contextualization to the hospital's involvement with de jure racial segregation:

> I think that because of this segregation and the definition that it was, I think that it defined [pause] to a certain number of people, it defined what it became. What it was and what it became. And I think made it harder to get that perspective: that was then, this is now. […] [T]he only place that they had, that the African American people had, to be hospitalized in the state system, was they had a place in the basement of the [other state facility]. They were segregated in a basement. It was started by the Freedmen's Bureau. It was meant to be a positive, "Here we want to provide the infrastructure for you. You will be able to farm and be outside and do various things." And so in that time, it wasn't what it feels like today.

By situating LPH's segregated past in the 19th century, Janet S. distanced the modern LPH environment, or "what it became," with that of its history, or "what it was." Furthermore, she portrayed the Freedmen's Bureau and LPH as helping African Americans, a minority group who would otherwise not have access to medical care. Janet S. pointed out that the hospital and the federal agency struggled to help the former slaves within the confines of a challenging social and political environment. She argued that the

negative connotations about care and treatment associated with LPH's past administrations could also be applied to the other large mental institutions in the state: "It was what mental health care was at that time." It was evident from our conversation that Janet S. strongly believed in the work that LPH is doing now for the mentally ill. She hoped that the hospital's history – which she appreciated as part of the institution's deep roots in the community – does not negatively affect the public's and state's perceptions of the current hospital administration.

I also discussed the legacy of segregation with Dennis H., and specifically how it can continue to affect the relationships among staff members and with hospital and state administrators. Unlike Janet S., Dennis H. described a continuous narrative from the hospital's 19th-century roots to its present-day atmosphere. As an African American in an administrative position, he bounds two worlds that were, until a couple of decades ago, characterized by racial division. As a result of his barrier-breaking role in the hospital as one of the first African American doctors at LPH, he has had interactions that point to the enduring acknowledgement of segregation among patients *and* staff members in the past. He told me,

> When I got here, people were happy to meet me and after a few years, I got to be closer to folks and I realized that my building is called the "White House." "How are you doing up in the White House, Dr. [H.]?" And some of that is LPH administration, but also it's that racial divide.

In his experience, when personnel would call the administration building the "White House," it was said tongue-in-cheek. The nickname is also a reference to a long institutional history of having few Black people in leadership positions.

While Dennis H. acknowledged the institutional memory of a racial divide, he also pointed out the uniquely insular African American community and culture surrounding LPH that continues to permeate daily hospital life. He expressed appreciation for the preservation of centuries-old customs that stood in contrast to the "paternalism" that some interviewees described coming from the central office and the hierarchical staffing structure within the hospital: "I found the nursing staff, the techs, to

be maternalistic. So they would bring in some food for some of the patients if they wouldn't eat, or they would bring in some clothes, or they would do different things like that." While ingrained cultural practices and beliefs can be problematic when abutted against contemporary hospital culture and practices, Dennis H. characterized the African American customs as a positive cultural influence on the hospital environment:

> It's a hospital, so it's got to be dietary, but you still you had some good ol' folks who would bring in a pot of beans or bring in a cake or, you know. So that folksiness, I think there was a closeness between the techs and the patients that I didn't see in some of the other places that I was. That's been a very nice piece of culture. I think it's been here for 400 years.

From Dennis H.'s point of view, the "maternalistic" relationships between patients and staff members were a unique and beneficial aspect of the LPH environment. While still hierarchical, the interactions were rooted in genuine care and concern that he associates with the "folksiness" of African American culture.

LPH stands out as a unique mental health care facility in its role serving African Americans during a century-long period of time when no other facility in the state would care for them. As evidenced from the records, the hospital was often understaffed, underfunded, and crowded with patients. The other mental hospitals in the state were also overcrowded, but not to the extent of LPH. Being the only institution in the state that was open to African Americans in need of mental health care, it was incontrovertibly more financially strained than the other facilities. During some time periods, care at LPH was far more custodial than medical. The hospital also faced greater public and administrative scrutiny than the institutions serving Caucasians because of its distinctive position in the state. Patients at LPH, both alive and dead, were not always treated humanely and with the respect that mainstream society expects today. While White patients faced some of the same mistreatment, African Americans undoubtedly faced the brunt of anti-miscegenation and eugenics laws. LPH is not without its triumphs, though, such as its early rejection of mechanical restraints and being the first mental hospital to seek national accreditation in the state. And as Dennis H. observed, the familial culture at the hospital

is arguably unique. The particular culture at LPH, born out of its insular purpose and unique position within a patriarchal state bureaucracy, makes the hospital's records particularly valuable for social histories and longitudinal epidemiology. I would argue, however, that the institution's singular history and culture are also the primary factors making the preservation of and access to the historical records especially challenging.

TRANSITION TO THE ARCHIVES

Laws such as HIPAA are necessary to help protect the privacy of record subjects. By restricting access to the personal health information of patients, these laws shield the patients and their families from unauthorized use of their medical information and risk of being identified from that information. If such legal restrictions were not in place, it is not difficult to imagine how individuals and organizations who gained access to medical information might abuse it. As I have noted earlier in my literature review of medical privacy, the laws and policies regarding historical health records may appear inflexible but are somewhat mutable in practice. They also inevitably change over time to accommodate new political demands.

While the current instantiation of HIPAA's Privacy Rule addresses the temporal nature of privacy and access with its 50-year restriction on decedent records, which presents a façade of completeness and fair resolution, it does not fully acknowledge the difficulty of determining what should become part of the cultural record. What I am interested in is how medical information laws and regulations and retention policies have been perceived and put into practice in the medical and archival work environments. Rather than revisiting the specific provisions of HIPAA, the Privacy Rule, and the state-level laws regarding the protection of patients' privacy and the retention, disposition, preservation, and access to "inactive" health records – which I discussed in the literature review – in this section, I focus on the personal viewpoints of my interviewees regarding what should happen to the historical hospital records and especially regarding the planned custodial transition to the state archives.

As an outsider who worked temporarily at LPH, I was able to observe and participate in the hospital community to only a limited degree. Yet I nevertheless had friendly interactions with everyone I met, from the hospital's top administrators to its cafeteria cook. I initially assigned these exchanges as instances of Southern hospitality; these everyday relations gave me a sense of safety, comfort, and overall social support in the LPH environment during my internship. Upon reflection, though, I believe that most of the informal social ties I had at the hospital were deliberate. Rather, my presence and archival work, which I recognize as being disruptive and strange when set among the everyday work environment and routines of the hospital, were greatly softened by the thoughtfully planned introductions to the hospital personnel by Dr. King Davis and others who have strong ties to LPH and are well-respected authority figures. They were the cultural brokers who allowed me to become partially integrated into the hospital's daily work environment. Without the proactive actions of these brokers, I believe I would not have been able to gain access to the LPH records, the personnel, or the grounds. I argue that this ethos of being protective of its own and wariness of outsiders emerged over the course of 140 years, in which the numerous iterations of the hospital's administration developed a culture of self-reliance and prudent measures to protect its limited resources.

Among my interviewees, there was a spectrum of viewpoints regarding the preservation of and access to the historical LPH records. While this finding was unsurprising, I was most struck by the complex and ambiguous feelings expressed by the hospital's administrators (Janet S. and Dennis H.), who were careful to distinguish between their personal and professional opinions. They talked about the challenge to balance their work duties with a private interest in the hospital's history. In addition, they and others (Robert L. and Cathy R.), albeit less explicitly, addressed the unclear boundaries of what is "historical" and "archival," and what is "private" and "for work use only." While they acknowledged the importance of preserving some of the documents, they also believed other documents should either be destroyed or, as outlined by Dennis H., not made accessible for a specific amount of time in order to protect patients and

record creators. Ann P., an archivist for the state who has extensive experience processing mental institution records, shared her personal observations regarding the relationships between historical asylum records and the institutions' personnel:

> I don't know if it's particular to mental health records generally or health records generally, but there's a really distinct emotional attachment to the record. And I know Larch Point Hospital has had a few folks who are very, very emotionally attached to the records.

I argue that the intense emotional connections that my LPH interviewees have with the historical LPH records emerge from a strong sense of duty to the hospital and their professions, whether they are currently employed or retired. They understand that the records, as archival objects, have the potential to be shared widely and publicly. With such exposure, the records can become the primary representation of a still-active hospital and a long history of the work it has done. The collection, however, does not portray fully the emotional labor, personal relationships, and the historical context of the work practices and policies that characterized the hospital. The fear is that the records could be used against the current administration. Nevertheless, the administrators (Janet S. and Dennis H.), as well as other staff members (Loretta M. and Robert L.), the archivist (Ann P.), and the social historian (Henry A.) attribute potential medical, cultural, and personal values to the LPH archival collection.[55]

At one end of the spectrum in regard to the destruction of records with private health information is Cathy R. Cathy R. was the only LPH nurse that I spoke with for my research, and she is the interviewee who expressed most strongly the need to destroy inactive patient files rather than preserve them for eventual access. Cathy R. prides herself on ensuring that her patients received the best care possible; for her, work was

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[55] It is important to keep in mind that most of the individuals that I selected for interviews were based on previous contacts and snowball sampling. Therefore, I do not claim that the opinions of my interviewees regarding the LPH archival records are necessarily representative of any LPH personnel except themselves. A skew among the interviewees toward support of the archives project can also be attributed to my presence and participation as interviewer *and* known project member.

more than "just a job." Thus, relatedly, she is proud of her fastidious recordkeeping. The keeping of records was an integral component of her job in order to better care for people, and Cathy R. kept personal notes regarding her patients that were for her eyes only. She said these notes were "just a mental reminder for me," and, when she was done with them, she made sure to destroy them herself. When I asked Cathy R. how she disposed of these informal nursing notes, she says, "I just put them in the trash, you know. They were out. They were destroyed." In contrast to Cathy R. being able to decide how and when to discard her personal records, she was not able to determine the preservation or destruction of official patient case files that she helped create.

Both Cathy R. and Betty T. expressed pride in the records that they created at LPH. In response to my question if she would consent to researchers and other members of the public having access to records that she created in the course of her job, Betty T., who was a clerk and administrative assistant, responded, "Sure. Yeah, because, well, I can't say they were all perfect, but see, I was somewhat of a perfectionist. I didn't like White-Out and I didn't like to erase, so therefore, it looked nice when it went out." Cathy R. conveyed a similar confidence in her recordkeeping ability when she said, "What I put in the patient's record, it doesn't bother me there's someone else reading it." Unlike Betty T., however, who appeared to be nonplussed by the idea of administrative and medical records that she created being made available outside of the hospital, Cathy R. believed her patient case file records have a very limited audience and use. In her interview, she expressed a strong desire for patient charts to be destroyed after they are no longer "active": "I think after the patient is discharged, after so many years, they should be destroyed." Her reasoning was that, if a patient was discharged then later readmitted to a facility, a new chart must be created because his mental condition may have changed "so you really don't need that old chart." Besides her practical, care-based logic for destroying charts after they are no longer needed for patient treatment, Cathy R. indicated her fear of how the inactive charts could be used, either against her or the patient, if they

became available to the public. She says, “You never know whose hands they may get into.”

Interestingly, while Cathy R. held steadfast throughout her interview regarding her belief that all patients’ records should be destroyed after they are no longer used, she also told me she was disappointed by the younger, new LPH employees’ not being familiar with the history of the hospital. She believed that if they did have an understanding of LPH’s past, they would take more pride in their work and have more compassion for its patients. Cathy R. said, “I feel that if they knew some of the history, then they would be more prone to be more committed and more dedicated.” When I asked how these personnel could gain a sense of the LPH history, genuinely hoping that she might concede that the LPH archives could be of value in this situation, she remained pessimistic about any solution, “I don’t really know whether they are really interested. I really don’t know.” Cathy R.’s nuanced and complicated relationship with the hospital’s records is bound with her other social ties, especially her fierce dedication to her profession and the patients she served. Therefore, Cathy R. believed the hospital’s personnel could benefit from knowledge about the institution’s history. This lack of interest in LPH’s past by some staff members was also noted by Janet S., who speculates that the disinterest is actually intentional.

As an administrator, Janet S. has observed some negative reactions toward the memorialization of the hospital and its history. In our interview, she wondered if these staff members view historical objects and memorials as painful reminders of the Jim Crow South and LPH’s role as a segregated facility. When talking about the relative lack of action in the past to preserve the LPH records, she suggested that some personnel would rather forget about the records and, subsequently, forget about the past: “I think that on some level, and I could be wrong, but I think that they didn’t pay attention to their history because possibly it was perceived as being shameful. So why would we want to save these things?” Janet S. acknowledged that LPH has a different racial and cultural heritage than the other mental facilities in the state. However, she also believed that any

current racial tensions should not be blamed on artifacts and commemorations of the past. To her, actants such as historical road markers and archival records are not the source of disagreements among staff members; rather, the personnel problems originate from differences in personalities and beliefs.

The actants nevertheless represent inequity and racism for some at the hospital. Janet S. expressed relief that the archival efforts have moved beyond the confines of the hospital, and into the hands of Dr. Davis and his team:

> And so thank goodness when people came and started showing interest, [the historical records] hadn't been thrown away or something. I mean, seriously – yes. So different kind of culture there as far as those kinds of – So I think now, King Davis came, he made it – he has given it some meaning, he's given it some respect.

As I gathered from my conversation with the archivist, Ann P., she did not face the challenge of garnering staff member "respect" toward mental institution records when she worked with other facilities to transfer custodianship of their archival collections to the state archives. On the contrary, she found some staff members in these other institutions to have a strong sense of ownership of the historical records and were wary initially of giving the collections to another state institution. Based on my interviews, it is clear that the LPH archival collection and the ongoing efforts to preserve the records continue to evoke emotions and opinions among the staff members regarding the impact these records can have on personnel relations, the hospital's public stature, and how the institution is remembered. For some, the collection also represents a means for the hospital to contribute productively to the culture record.

On the other end of the spectrum from Cathy R. in terms of if and how the LPH historical records should be preserved and made accessible are the individuals who are involved in the archival project. Their exposure to both the historical records themselves and the enthusiasm of those who seek to save the collection appear to have influenced their personal viewpoints regarding the potential research value of the records. In contrast to Cathy R. who does not wish for records with private health information to be made

available to the public, Robert L. and Dennis H. are the two LPH staff members that I interviewed who strongly advocate the long-term preservation of inactive records and whom the U.S. National Archives and Records Administration (n.d.) would label as "citizen archivists." They are both very familiar with the LPH archives project. Over a decade ago, Robert L. took part in a staff member-led effort to collect the historical records from around the hospital's campus. He says, "At the time, I tried to do what I could to help [the staff member], to move [the historical documents] along, and to this day, I'm still doing the same." Once Dr. Davis and the rest of the team became involved, Robert L. continued to assist with the project. Meanwhile, Dennis H. has expressed a great interest in the history of the institution and has supported consistently the project as both an LPH administrator and as an amateur historian.

Robert L. and Dennis H. envision the archival LPH records being used for social histories of medicine. When I asked Robert L. if he thought modern records should be preserved for future research, he said, "It's all important. It's a matter of how much resources that you have." In Robert L.'s opinion, the "old" materials from the first one hundred years of LPH's history have great potential value now as primary sources to better understand the growth of psychiatry as a profession and institutional care in particular. With the registers and the board meeting minutes, he says, "You can see the changing in the focus, the treatment model, and how the society or the staff would conduct business differently." Similarly, Dennis H. marveled at how the records can show health care providers how mental illness etiology and treatments have developed over time. He pointed out, however, that the historical records also illustrate the wide variety of mental illnesses that continue to remain beyond neat categorization, despite the efforts of psychiatry:[56]

And then when I came here [to LPH], probably in that first year or two,

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[56] For a recent popular article on the contemporary attribution of post-traumatic stress disorder to U.S. Civil War veterans, see Horwitz (2015).

> spent some time, you know, the tourist, just pulling [records] out and turning the pages and feeling signatures and notes from 150 years, 130 years ago. And seeing even though it was different vocabulary, uh, we haven't made a lot of forward movement. If you really look through the records, some people have behaviors, some people have a mixture of behavior, and something going on with their brain. Some people have some medical problems that affect their brain, and then some people have some pure madness. Even though we've got different words through DSM I, II, III, IV, and V, we're kind of the same place. We don't quite know what is going on with each person. Each person is an individual and some people have organic brain problems and many people have behavioral problems, and some people have diabetes or thyroid disease that manifest as a – so that was always interesting to me that the more we change, the more we stay the same.

It is evident from his statement that Dennis H. has an appreciation for LPH's historical artifacts, including their tangible qualities, e.g., the feel of old signatures, the tactile sensation of turning pages. He admires and is curious about the medical efforts conducted by the early LPH doctors, his predecessors, and casually has used the records to trace changes in care for health issues that he sees today among his own patients at the hospital. Throughout my interview with Dennis H., he consistently spoke from the perspective that LPH's history is one long narrative arc, with individuals, decisions, and policies cumulating to affect collectively the cultural environment at the hospital and make it what it is today. Therefore, it is perhaps expected that of all the LPH personnel that I interviewed, Dennis H., most strongly advocated in his conversation for the preservation of the LPH archival records, even if access had to be denied for a finite amount of time.

All of the interviewees who I spoke with firmly believe that there is a need for laws such as HIPAA and the Public Records Act to protect private health information. However, I found there to be a spectrum of personal opinion, including uncertainty, regarding the manner of restrictions and how long they should be. This speculation is especially evident with the LPH administrators, who shared their personal opinions with me regarding public access to the historical hospital records, including the registers and

minutes. The differentiation between "active" and "inactive" records in the medical sense is clear cut in theory, if not in practice, as there are prescribed records management policies, e.g., weeding procedures and time limitations, regarding the retention of patients' medical records after they have been discharged or died. The readjustment to thinking of these records for purposes other than only in-house, personnel use can be difficult.

The delineation between what is "historical," and thus worth saving for public access, and what should be destroyed after its intended use is unclear, especially to those who continue to create records at the hospital. As Robert L. noted, in regard to his work to collect and sort historical LPH materials for the archives, "Before I knew it, I was in the photos." Janet S. pointed out that most staff would be uncomfortable, as Cathy R. was in our interview, about the idea of the products of their recordkeeping work having value beyond the hospital:

> Now, most of what I worry about are are we putting information in there, are we documenting well our clinical actions, our clinical justifications, what we are doing, and thinking about them as history. It's kind of hard for me to make that shift. Because that sure isn't what we're writing for.

For someone like Hilary Jenkinson, who viewed records as evidence of transactions, the lack of self-consciousness among hospital personnel about both their recordkeeping practices and the potential for their records to become archival documents is what would make the records valuable. In other words, the "internal functionality of the documents" (Duranti, 1994, p. 341) is preserved, without any outside influences beyond the hospital's primary purposes. However, unlike Jenkinson's intent for the record creators to get to choose what goes into archives, the personnel that I spoke with do not have such an option. The materials ostensibly to be preserved and eventually sent to the archives is state-mandated. A self-consciousness about their recordkeeping practices is arguably already felt by LPH record creators, at least in the sense that they know the destruction or preservation of their records is outside of their control.

Janet S. articulated a concern that is also alluded to in my interviews with Robert L., Cathy R., and Dennis H. She noted the challenge for personnel in the medical profession to think of their own records as becoming historical documents, despite their support of the 19th-century LPH documents being preserved and made accessible to a wider audience:

> So I think [staff members] will be pleased to know that [the historical records] were protected and that someone else would have access. That being said, I think, most of them there would go, kind of this – what I was saying – on a different level, "But I don't want the stuff I'm doing now to become historical archives anywhere. We don't want our own stuff to do that." [laughter]

The contemporary record creators at LPH have difficulty seeing documents of their own making as ever becoming archival artifacts. The records produced at LPH, first and foremost, are for the purpose of accomplishing hospital business, whether that is medical care or administrative work. Other potential uses, such as sociological or historical research about the hospital or its patients, are a secondary concern. According to Janet S., the hospital must strive constantly to demonstrate accountability – in the contemporary sense of an organization having to account for its performance of duties to government administrators – through their records. With the advent of LPH wading into archival/historical territory, the hospital administrators are now having to address the institution's actions, past, present, and future, in a historical context to a broader audience. Privacy laws for medical records and, to go back much further, the Hippocratic Oath exist to help doctors gain the confidence of their patients. As Dennis H. said, "If it's protected, people will say more things to me and that helps me to help them." Therefore, it can be understandably disconcerting to the record creator if those very records that emerged from a private and confidential relationship between patient and doctor have the potential to become available as archival material.

Dennis H. viewed the patients' records as active or "alive" as long as the record subject is alive, whether he is being treated by a mental health facility or released. He

said, “When that patient goes away [e.g., is discharged], there’s a good chance he’s going to come back because mental illnesses tend to be chronic. […] So for 30 or 40 years, that record is alive.” His comments echo one version of Schellenburg’s archival concept, the record life-cycle, in which organizational records have two distinct phases, first under the management of its creating institution and then under the custodianship of an archives. When a record’s existence is connected to the record subject, or an actant is bound to a particular actor until his death, then the record could be considered in its first phase. Then the record has a secondary life as a historical or “inactive” artifact. After the individual dies, Dennis H. said, “I think that, by and large, records should become available.” He added on another 10 to 15 years after death to accommodate the potential privacy wishes of the patient’s family. Dennis H. reasoned, “So everything that is older than the ‘60s or ‘70s, both administrative and personal, it seems to me that it’s outlived its usefulness for care and even care of family and probably should be available.” Dennis H.’s personal views on the ideal length of time to restrict access to decedent records is much less than what is allowed by HIPAA or state codes. The archivist, Ann P., noted that there are others who agree with Dennis H.: “The [state archives] was part of the lobbying effort to reduce [access restrictions] to seventy-five [years] for privacy-protected information. So that was a victory for us, but to some, it’s still too long.”

Both the doctor, Dennis H., and the archivist, Ann P., provided me with anecdotal evidence that, in their experience working at hospitals and archives, respectively, they have not encountered family members of deceased patients who were upset by the availability of too much information about their institutionalized relatives. On the contrary, Ann P., told me,

> Well, I’ll say that every call I’ve received, and this hasn’t happened in a while, but every call I’ve ever received when I was in state records, when we couldn’t serve what they wanted to see, it was always that they were upset that they couldn’t see it rather than upset that they could. Like, no one has ever, to my knowledge, complained that these records are available. If anything, they’ve complained that they are not available

> enough. So that the seventy-five years is still too much, even though prior to, I think, 2006, it used to be one hundred years.

Dennis H. gave a similar account of not hearing complaints regarding access to historical records that are being kept at LPH:

> No, I don't know of any problems that are a consequence of somebody having access. I haven't heard anybody say, "Oh my God, my record – my grandfather's record was opened and this is the problem that I have." I haven't heard any. So I don't know why we should spend much energy protecting it at that point.

These descriptions indicate the need for future studies that focus on the intellectual, emotional, and social needs of potential users of historical hospital records, including patients' families. What would it mean for the relatives of decedent patients if restrictions were relaxed further than the current Privacy Rule revisions?

In her interview, Janet S. did not suggest an alternative to the Privacy Rule's timeline for access to private health information. She did, however, discuss at length her personal struggle negotiating the needs of patients, their families, and their descendants, with the importance of allowing patients' records to become part of a larger cultural documentation of LPH in American history. She said, in reference to the federal- and state-level decisions regarding the destruction and retention of hospital records, "I don't know who figures those things out, but I'm glad it's not me." Janet S. wants to protect the hospital's patients, but also appreciates the long-term historical value of records:

> So I think that the history is important. We are still open, and I feel like that we have moved away from the negative connotations of our history, and so I am always of two minds in my position of pride in the history of what it was and the awesome things that happened there and just what history was. […] But I don't want our history to suck us back into any negative connotations. So I'm kind of fighting to hold pride and not somehow let it redefine us in a way that is not positive. […] [With the hospital] still being open, still being [able to sit] in the middle of some of the buildings that look like they were there back in the 1800s. I think that it's much easier to feel that kind – so I'm a little sensitive about that part of it.

As a current administrator at LPH, Janet S. is understandably very protective of her institution. She worries that the wrong kind of exposure for LPH could negatively "redefine" the hospital both in the public eye and among its personnel. Simply by working on a hospital campus that has existed for nearly 140 years, the staff is reminded unavoidably of the hospital's long association with segregation. In her job, Janet S. must be extremely tactful and cautious regarding the archives project. Personally, however, Janet S. views the historical documents as an important part of the cultural record that is not available currently to most people.

Echoing Loretta M., who alluded in her interview to modern case files as being far more detailed (and thus assisting with more personalized care) than in the past, Janet S. reflected on the differences she perceives in the active records that she sees at the hospital today and those in the archives. She believes that the information found in 19th-century records in particular would not likely be harmful to descendants because of the amount of time that has passed and the brevity of the documents:

> So I look at some of the things in the records of some individuals right now, and they are so detailed into their behaviors, their social histories. So detailed that I wouldn't want to think that maybe their great-great-great grandchild would come upon this information in a history. And I've looked at a lot of stuff in our archives, and I just think it was not as potentially damaging as some of the things are now.

Janet S. recognizes that she is only able to assume that 19th-century medical documents do not have damaging information because she can make comparisons between those historical records and the modern ones that she sees being created at LPH today. Reflexively, she is aware of her position in the hospital's long history and how her decisions will help determine how the hospital is both remembered and continues as an active care facility. Janet S. addressed with uncertainty her administration's role in the future historiography of LPH,

> Maybe it's just where you stand, but I worry a little bit about history's history, and this will be the history of – but I kind of worry about at what

> point do we owe it to the people to protect them? Because they may be dead. Their children may be dead.

Janet S. wondered how many generations it takes in order for the descendants of patients to not feel harmed if they knew their ancestors' mental health records were publicly available or if they saw the medical information written about their relative. She speculated that, if she had had ancestors who were institutionalized in the 19th century, seeing their records would not cause her "psychic pain." However, Janet S. was quick to note, "I'm not a historian. I love history, but I don't know if I'd love it so well if it was about my ancestors."

The current administration's blurry moral responsibility toward its former patients and their descendants is tied intrinsically to the hospital's adherence to the Privacy Rule's regulations, as well as the state's desire to shield itself from potential legal repercussions in regard to the treatment of patients in the past (e.g., shock treatments and lobotomies). Many of LPH's records that would be popular for social history research would also be the archival collection's most controversial, such as the ones that deal with sterilizations, a standard procedure for many decades in state hospitals across the U.S. Dennis H. observed,

> [The state] doesn't want to talk about [sterilizations] quite yet. It kind of comes up every once in a while. But the one of things I think I heard long ago was that we don't quite want to open up the [LPH] records because there's a lot of stuff that's – a lot of things happened 40 years ago.

By comparison, North Carolina lawmakers have been working since 2003 to find ways to give financial restitution to an estimated 2,000 surviving individuals who were involuntarily sterilized between 1929 and 1974 (Kessel and Hopper, 2011). For an active hospital such as LPH that has a charged racial history and is continuously building and maintaining good relations with the state, its personnel, and the surrounding communities, the opening of records that reveal the extent of the hospital's sterilization practices could be devastating. Acutely aware of how hospitals such as LPH and St. Elizabeths have histories that are rife with "good parts and the bad parts," and cannot be

changed, Janet S. was cautiously optimistic that others can someday look at LPH's past with detachment:

> Well, you know, when you look back on the history, it's kind of like, we did a bunch of prefrontal lobotomies here. […] It still is fascinating and it's still part of the heritage, and the part of the fascination comes with the comparison that was then and this is now.

Some people may never be able to look at particular LPH records with emotional disinterest and accept "that was then and this is now," as Janet S. hopes. However, this does not mean that the LPH archival records cannot contribute to the cultural record, medical knowledge, or an individual's personal growth in ways that are unexpected and new. As Dennis H. pointed out, "I don't want [records] to be destroyed because we don't know the questions yet." Due to the preservation efforts by individuals such as Robert L. and the support of Janet S. and Dennis H., nearly complete sets of historical minutes and registers from LPH continue to exist and will be preserved in both their original formats and in digital form. The level of future access to the historical LPH records lies in the fluctuating relationship and ongoing negotiations among three collective actors: the archival project team, the hospital, and the state archives.

As I have noted before, the state archives is the designated repository for many LPH record types, including the registers, minutes, commitment papers, and annual reports. According to the former archivist and current records manager at the state archives, Ann P., the state archives has a records code that demands it must accept any state facility records that were created in 1913 or earlier. The archives, however, has the discretion to appraise what it receives. Ann P. told me that a modern retention schedule simply does not apply to these materials, and they would be considered to be within the scope of the archives' collection policy. In her experience, almost nothing that the archives has received from the state's mental institutions has been discarded: "So those things that we might disregard today as boring – you know, financial stuff or administrative stuff that have very short retention – they decided to keep." Echoing Yates' (1989) emphasis that internal management records are the key to understanding an

organization's structure and operations, Anna P. explained that, in her experience, these "boring" records are particularly useful for researchers who are interested in mental institution administrative practices: "It's the sort of stuff that it seems like it painted a better picture of the entire organization of the hospital, of how it ran." The state archives already holds collections from several other mental institutions. Those collections span from the institutions' inceptions to modern day. For its pre-1913 records, LPH has the option of retaining those records in its own facility or to give them to the state archives. The bulk of the hospital's historical records remain in the hospital's medical records department. The collection has been moved several times by Robert L., and the current room that it is stored in has also been used by the hospital's psychology department as a transfer point for some of its records. At the time of my interview with Robert L., he was concerned about the unstable archival storage environment at LPH, "So right now, there's no space. It's just so packed. It's even difficult to retrieve things."

Although the process to transition institutional state records from active medical documents to archival ones has been determined by the state's record managers, the procedure is complicated by the social relationships between the state institutions. The negotiations to move the LPH archival collection from the hospital to the state archives is ongoing at the time of my writing in spring 2015. In 2009, Ann P. travelled to LPH with a colleague to make a presentation about records management and the transfer process between the hospital and the archives:

> I was there to sort of help clear up any past misunderstanding about what happens to records when they're transferred out, you know, archival records, when they're transferred. There was some, um, concern, I think, there that we were telling they had to get rid of everything. I'm not sure where – we don't know where that came from. […] [Some staff were] very concerned that there was something in the Code that said they had to destroy stuff. And we were trying to go down there and ease their minds that, "No, no, you know, we're not asking you to destroy stuff from, you know, 1870. We would actually like you to transfer that stuff to us."

According to Ann P., the archives has never pushed strongly for the collection to be

transferred because the archives personnel "really don't have any teeth to say, you must give it to us. We don't want to alienate anybody, you know." While I would not characterize the LPH administration as alienated by the state archives, the hospital administrators do, however, continue to not have an accurate picture of what the state archives can provide for the collection.

Interestingly, from the perspective of all of the hospital staff members that I spoke with, the state archives is not the institution that first comes to mind when contemplating how and where the LPH collection can be preserved sustainably, despite the efforts of state archives personnel to clarify the archives' custodial role. As Ann P. explained:

> [E]very agency is supposed to have a designated records officer, and that records officer is supposed to be in contact with their assigned records analyst. […] There's supposed to be a relationship. We're supposed to serve as like a consultant, liaison-type thing to help them manage their records in accordance with the Code and the Public Records Act.

I believe that the verbal and written discussions between LPH's records officer and the state archives' records analyst and between the records officer and the hospital's administrators regarding the transfer of LPH records have not always been consistent or comprehensive. In my discussions with LPH personnel, suggestions for permanent archival housing included the hospital itself, the local public library, and a nearby college; yet legally, the only two facilities that can have custodianship of the LPH records are the hospital and the state archives. One hospital staff member did not think the state archives had an "obligation" to take the LPH records. Another said the state archives would be the ideal repository, but "I don't think they want them. But it's maybe worth exploring." There is a persistent impression that the state archives does not have the manpower or funds to care properly for the collection.

Robert L., who has been able to participate in and observe the developments in the archival efforts over the years, continues to worry about the long-term preservation of the collection. He reiterated the fears held by some staff members that spurred the initial efforts from Dr. Davis to protect and preserve the records. In reference to the digitization

component of the project, he told me at our interview, "Once we're done with it, we need to figure out what to do with it. Because otherwise, we'll run out of space and no one wants that. And we would go to the dump, and I don't want that to happen." I believe the state archives needs to take on a more proactive role in advocating for the transfer of the LPH records to the archives' facilities as a means to alleviate the hospital's records storage problems; space-saving measures spurred the custodial handover of collections for two other mental hospitals in the state.

Based on my interview with Ann P., the state archives has been cautious approaching state facilities such as LPH about their records. In the early 2000s, two other historical but still active mental health facilities in the state transferred their inactive records to the state archives. Ann P. described these events as happening very quickly because these two hospitals were moving sites and the administrators did not know how to accommodate the older records that had accumulated. According to Ann P., the hospital's records officer and other staff members were highly involved in the transfer. She says of the unusual experience, "They were very involved. It's not really the normal level of involvement with agencies that deposit records with us. They were very much, I think, personally interested as well as professionally interested in the records."

The other hospital, on the other hand, had personnel who were initially more leery of the custodial shift because of a decades'-old mistrust of the state archives and concern about what would happen to the records once there. The doubts of the second hospital's personnel are similar to those held by some key records management and administrative personnel at LPH. Ann P. elaborated, "People who had worked with them for thirty years plus - they were hard pressed to let [the records] go without knowing that they're going to be taken care of." The state archives helped to allay these fears by assuring the hospital staff that they would still have access to the records once they were transferred to the archives and by providing tours of the repository to show that whatever negative perceptions they had of the archives were not true.

Ann P. emphasized the ways in which her institution has worked to make records accessible once the archives receives them. Specifically, the archives is active in making collections available through processing, electronic finding aids, and some online digital collections. According to Ann P., archival personnel also seek out potential users for collections:

> Our goal here at the Library is to see [the records] be used, and not withheld. We're very conservative about restricting. We try to make it as liberal as possible, as open and transparent as we can. So our interest is in making these collections accessible and finding people who will appreciate them and will use them.

The current visions for the LPH collection held by the hospital administrators and the state archivists are compatible. However, the ongoing relationships and chain of events that have led to the LPH records' remaining in the hospital is obviously different from that of the other state hospitals who gave their historical collections to the archives. A custodial transfer that is supported by the LPH actors may require the project team to act as facilitators and to provide assurances regarding the long-term preservation of the collection and the hospital's continued access to the records when needed. It is my intention to have Ann P. and her colleagues from the state archives speak again with LPH administrators. Ann P.'s assurances about the care that the collections will receive and the archives' commitment to access would assuage the fears of individuals such as Janet S., who said in her interview, "I think that the people who care about [the records] would be glad they were going somewhere where they would have a life." The LPH administrator's comments recall Dennis H.'s vision for LPH records to have a secondary existence as research material.

When I asked Ann P. about the amount of use of the LPH records that have already been transferred to the state archives (e.g., commitment papers), she noted that LPH has the smallest collection so far of the state hospitals with records at the archives. If the archives were to receive the rest of the LPH records, especially the registers which are commonly used for genealogy, she says, "I think it would benefit if we ever in the

future were to get the rest of it, I think that would change dramatically because of the uniqueness of what's there versus the other hospitals." In the next section, I deliberate on my findings regarding the limitations and values of the LPH collection as an archival resource. In particular, I focus on the role of organizational records in the commemoration process.

COMMEMORATION AND UNDERSTANDING

This final discussion section is about the potential uses and values of the LPH historical collection as archival documents for the hospital and, more broadly, for research purposes outside of the hospital. While some parts of this section are necessarily speculative, I base my discussion on my knowledge of the LPH collection, my interview with the social historian, Henry A., and the works of scholars and popular writers regarding their encounters with archival resources. I first outline the formal efforts by past LPH administrations to revive interest in the hospital's heritage, and contrast it with the popular assumptions about the mental institution among members of the communities surrounding LPH. Then I discuss the potential for the archival records as a heritage resource for the hospital. I argue that the archival collection, as long as it continues to survive and become available (and potentially more widely and easily accessible in digital form) to interested current and former personnel at the hospital, can become a more substantive part of LPH's institutional memory. The records were once part of everyday work practices, and they already have become artifacts of remembrance at the hospital for a few staff members with personal interests in the collection. Otherwise, as I discerned from my interviews and the Board minutes, engagement with the hospital's history via the archival records has been, for the most part, infrequent and cursory.

Next, I posit how the expansion of the archival records' availability could alter the way that personnel at the hospital, community members, and patients' families view the hospital. I first talk about the limitations and areas of silence in the written texts. Then I posit the idea that the scholarly work of outside researchers will be vital in the expansion

and deepening of people's understanding of LPH's role in the local African American community and the progression of institutional care in the U.S. Mindful of the ethical and legal risks of revealing sensitive information, I then examine the opening of the LPH collection as an impetus toward the building of "collective memory" as framed by Taylor (1982), and even perhaps a "community of memory" as envisioned by Ketelaar (2005) that could involve the hospital, researchers, and local individuals and families with ties to LPH. Finally, I look toward the future to examine how digital technologies and oral narratives can be integrated into the LPH archives and help the hospital, researchers, and other users engage with and contribute to a more diverse range of voices in the LPH community.

LPH's Heritage and Reputation

Within the LPH community, there have been sporadic administrative and individual efforts to commemorate the hospital's unique history, usually from a high level, institutional perspective. Commemorations organized by the hospital administration or the state board always have been distanced discursively from the current activities of the facility in order to emphasize LPH's contemporary advancements. The first commemorative actions taken by the LPH administration that I found in the meeting minutes was from July 1929. At this time, the Board approved and paid $50 for a commemorative marker to be erected in front of the hospital by the State Conservation-Development Commission. The marker's inscription, which was developed by a past LPH superintendent, notes the hospital's origins as an asylum for Blacks after the Civil War. Then in October 1933, at a hospital board meeting, the current LPH superintendent at the time gave an impassioned speech to the state governor regarding funding during the Great Depression. To emphasize the value of the work being done at LPH, he spoke at length on the hospital's history, noting it was "the only state hospital in the world exclusively for Negroes." He also claimed that LPH "has earned for itself an enviable name in the Psychiatric World" and was advancing scientific care and treatment

for the insane, but that status would change if the facility did not receive more assistance from the state. The historical marker from 1929 was mentioned again in November 1968, when the LPH superintendent told the State Board that the sign had spurred his interest to look through some of the hospital's historical documents. After conducting his research, the superintendent sought clarification from the Board about the founding date for LPH so that he could start planning the centennial anniversary. The celebration would eventually take place at the end of the following year, surrounded by a flurry of activities such as the construction of displays at the hospital and the publication of a newsletter titled, "Into a Second Century of Service." The public centennial event served as a means for the administration to form deeper bonds with its staff and the surrounding community. The other state hospitals in the state held similar anniversary celebrations for their own institutions during the 1950s and 1960s. Furthermore, like the LPH superintendent, the administrators at these other facilities expressed interest in their hospitals' old records, supported archaeological digs on their ground, and assisted with the addition of hospital buildings to the state's historical landmarks register.

The historical marker that led eventually to the 1969 centennial celebration is the same object that Janet S. noted in her interview as the focus of blame recently by some staff members for ongoing interpersonal tensions. Individuals and groups are continuously imbuing different meanings (i.e., emotional, cultural, and intellectual denotations) to objects such as the marker and the archival records.[57] The communities from the surrounding areas have also attributed various significations to the institution that have changed over time. Several people that I interviewed grew up in the areas surrounding LPH. Two interviewees, Loretta M. and Cathy R., are African American

[57] Cf., Kenneth Foote's (2003) discussion about sites of violence, especially how these places are "held in a limbo of conflicting emotions; someone will object to what is done regardless of whether the site is marked, ignored, reused, or memorialized" (208).

women, and they told me about their impressions of the hospital during their youth. I asked about their perceptions of LPH prior to their employment and found that, among the Black community, there is a long history of social stigma attached to this facility. Cathy R., who was a child in the late 1930s and 1940s, told me, "I always said when I was growing up and going to high school, and I would pass there, I would say, 'I would never work at that place.'" When I asked Cathy R. to expand on why this was the case, she explained that there was the perception that "people were crazy and they would attack you, and all that stuff." Similarly, Loretta M., who grew up during the late 1950s and 1960s, said that, before she began working at LPH as a clerk, she was afraid of interacting with patients:

> I really didn't know if I wanted to go there because I had never really – I didn't know anything about mental illness and I was kind of afraid that I wouldn't be able to work with patients or be around there. You know, you hear a lot of stories when you – like I said, I had never known anyone who had been sick or anything.

While Loretta M. and Cathy R. are of different generations, they both grew up with similar apprehensions about LPH patients that appear to be based on "a lot of stories" that they heard within their communities. Dennis H., who did not grow up near LPH, nonetheless had a cultural upbringing similar to that of Loretta M. and Cathy R. in which an African American mental institution was nearby and not well understood by most of the community despite being a major employer and health care provider. He described how the hospital was a part of the everyday lexicon among the youth in his neighborhood:

> In Raleigh where I grew up, it was part of the lingo that "You acting crazy. We're going to send you to Cherry Hospital." Cherry's in Goldsboro. […] "You crazy. You're going to LPH." So it's part of the lingo, whether you are at church or at school or playing the dozens or playing basketball.[58]

[58] "Playing the dozens" is a verbal competition most commonly seen in African American communities in which two competitors, usually male, exchange insults. The jokes are typically about the other person's

Like LPH, Cherry Hospital is a mental institution that was founded in the 19th century to serve African American patients. During Dennis H.'s childhood, the hospital was a fixture in his community as a source of derision. Cherry's reputation, whether based on specific narratives or abstractions, overshadowed the people who lived and worked there.

For these three people, the general attitudes toward the local mental institutions in their respective communities helped shape their perceptions of the mentally ill until they started working with them. Both Loretta M. and Cathy R. emphasized in their interviews that anyone could find herself in the same situation as these patients; Cathy R. noted that "mental illness has no boundaries." Loretta M. said that her attitude toward the mentally ill, and specifically the forensic patients, changed once she began "taking note of a person's background to know things about them." The revelation that Loretta M. described came not from working directly with patients, but from working on patients' records. If we extrapolate from Loretta M.'s situation to encompass a broader audience and an older set of records, the records in the LPH collection can help alleviate the persistent social stigma surrounding mental illness, the mentally ill, and the institutions for this afflicted population. Next, I examine the LPH records in the context of an archival resource, and specifically what they lack in terms of content and perspectives.

Record Silences

As I have shown in my discussion about the archival collection, the LPH records illustrate administrative decisions and patient intake, among other things. The records,

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family. The origin of the game and its name are disputed, and little academic scholarship has been written on the subject, but several recent theories suggest that it originated as a technique employed by African American slaves to settle disputes without resorting to physical violence, which could lead to punishment (Lewis, 1994; Saloy, 1998). The name may be in reference to the slave trade practice of selling elderly and infirm slaves "by the dozen."

however, provide only an abbreviated and often sanitized picture of hospital life from a limited number of perspectives. To recall Trouillot (1995), there are four potential moments for silence when constructing history: records creation, the creation of the archives, the summoning of records in order to produce historical narratives, and the act of remembrance. I will come back to the second, third, and fourth silences later. To address the first silence, in which information is not recorded, it is necessary to think about the original purposes of the records. I illustrated the role of hospital records in general in my literature review of the sociology of institutional records creation and as they specifically pertain to my research site in my discussion of LPH records as powerful actants participating in institutional accountability practices. Hospital psychiatric workers created records as part of their everyday practices in order to support their institution and, more generally, their medical discipline.

The LPH records, as actants that once assisted in daily hospital activities, have limitations as historical resources, especially in the provision of insight into the viewpoints of implicated actors. While I have already noted that patients, the subject of many of LPH archival records, are implicated actors, another group that also has little or no voice in the records are the hospital clerks. While the clerks produced the bulk of the records, especially starting in the era of typed records, audio dictations, carbon copies, and photocopying, their personal voices (e.g., opinions, decision-making processes) are absent. Instead, they produced official records using the words of medical staff or organized the records made by others. Loretta M., who was a LPH clerk starting in 1976, recalls belonging to a treatment team that consisted of a psychologist, a psychiatrist, a social worker, an occupational therapist, a recreational therapist, nurses, aides, and sometimes a nutritionist. She says, "I typed for the psychologist, the psychiatrist, social worker. I didn't do any typing for the nurses. Most of their information was written in their forms." She was also in charge of putting the forms in the right order in the patients' charts: "When a patient's medical record is already prepared, forms, everything that's needed is already on the chart, so when the staff sees the patients, the papers – the forms

– are already there." Ideally, clerks created and organized records so seamlessly within the daily patient care activities of the hospital that their labor was invisible to the medical staff. Recall Strauss' (1985) articulation work and how this type of labor is performed in tandem with well-defined tasks (e.g., medical procedures), but staff members often do not recognize the former as being an integral component of a larger work process. Thus, those I interviewed who produced or organized records that were based on the words of others tended to view themselves as being outside of the medical work that was being conducted at the hospital.

Loretta M. and Betty T., who were both clerks during their early years at LPH, expressed to me their admiration of the hospital's strides in advancing treatments and being compassionate to patients who had been considered hopeless cases by other facilities. Loretta M. observed that LPH does not appear to get the recognition she believes the hospital deserves, especially for its ability to treat patients that the other hospitals are unable to treat "for whatever reason." She said,

> See, by not working as an aide, I don't know, but I would think that if they were really being commended for the work that they did at LPH, aides, psychologists, doctors, that it would be – something mentioned on the news, something in the newspapers, write-ups about them. Maybe because it's mental health, I know you got to be careful because you couldn't give names of patients and things like that, but just, still, say the work that they do – when are they commended for it? I've always wondered about that, as I've been there through the years and just what I seem to observe. I've always wondered, do they get commended in ways – for what they do? They do an excellent job. Far as I could tell, they do an excellent job.

Throughout her interview, Loretta M. gave the medical personnel a great deal of praise for their caretaking. Meanwhile, she downplayed her own role in the functioning of the hospital by noting that she was not an aide and can base her opinion only on "just what I seem to observe." Both Loretta M. and Betty T. did not see themselves as contributors to patient care. Instead, the pride they have in their work stems from being accurate and precisely transcribing the spoken words of the doctors, whom they view as *their doctors*. They see themselves as the administrative extensions of the medical staff. The

disjunction between the relatively well-documented work of the doctors and boards and the unacknowledged contributions of administrative staff members speaks to the challenge for researchers to construct the lives of implicated actors based on institutional records alone.

In his book on the heath conditions of African Americans after the Civil War, Downs (2012) writes at length of his struggle as a historical researcher to gain insight into the lives of emancipated slaves through archival records. In his personal experience, the archival records did not adequately address his inquiries:

> The archive exemplify the challenges of understanding freedpeople's experiences. Boxes labeled as containing relevant documents about freedpeople's health instead held administrative correspondence and statistical charts, with notes mostly about freedpeople's labor. Even when details about medical conditions were forthcoming, they did not offer a clear and dependable portrait of freedpeople's health. [Freedmen's] Bureau doctors did not often record health conditions in great detail but used terms such as suffering, sickness, and diseased. Even when they did reference smallpox or cholera specifically, it is unclear if they were actually seeing these illnesses or projecting their own understanding of disease onto freedpeople's bodies. (p. 169)

The history professor continues, "Any study of freedpeople's health will invariably be incomplete given the ways in which these bureaucratic structures operated and the mechanisms in place to gather information" (p. 170). He alludes to the original, bureaucratic purposes of hospital documentation, which can be used as a means to reinforce dominant notions about marginalized people. While Downs writes about archival records as a limitation to his research, his caveat exemplifies how official hospital documentation was created for specified and often immediate purposes and not necessarily intended to become archival objects. I argue that what may be viewed as a research constraint by some can also be seen as an opportunity to better understand institutional recordkeeping ecologies and how bureaucratic records shape medical relationships and patients' identities.

Sociologist Harold Garfinkel (1984) examined clinical records and concluded that these documents "consist of procedures and consequences of clinical activities as a medico-legal enterprise" (p. 198). That is, they are intrinsically tied to "the social system that services and is served by these records" (p. 192). Echoing Garfinkel, Ciaran Trace (2002) found that record-creators in service organizations tailored records in anticipation of specific readers and with the understanding that records, by confirming narratives of the institution and its members, can justify actions. Garfinkel notes his struggle to resolve the apparent dichotomy of records being viewed as either a "record of a therapeutic [social] contract" or an actuarial record (i.e., archival record for social science purposes) (p. 198).[59] Garfinkel says these purposes reflect a "competing priority of value" (p. 206). He notes that the clinical record reader must also have a priori understanding of what presumably happened but was never recorded: "the known episodes [are] interpreted in the light of what one must reasonably assume to have gone on while the case progressed without having been made a matter of record" (p. 205). The assumption behind the records (which to Garfinkel, assumedly, means both the pre-printed medical forms and the written remarks by members of the staff) is that the reader of the forms is comprehending them as a medico-legal document, and already knows what a typical or "correct reading" of a case folder looks like, e.g., what a normal relationship and interaction between the record keeper and patient look like: "The possibility of understanding is based on a shared, practical, and entitled understanding of common tasks between writer and reader" (pp. 200-201). Loretta M.'s descriptions of her daily work practices exemplifies this understanding of what files should look like in terms of physical characteristics, content, and order.

When looking at clinical records for "actuarial" purposes, according to Garfinkel, social scientists should consider the records as serving a specific institutional purpose, a

[59] I cannot help but speculate what Garfinkel would have posited if confronted with the continuum theory from the archival field.

sentiment that is articulated further by Stoler's (2009) argument to "read for [a record's] regularities, for its logic of recall, for its densities and distributions, for its consistencies of misinformation, omission, and mistake – *along* the archival grain" and thus examining "the power of production of the archive itself" (p. 272). Ideally, researchers should be aware of the intent behind records' creation, the stakeholders involved in the activity and their relationships with one another, and the larger political-social context of the time. Archivists can play a role in the contextualization of how a particular record, action, or individual fits within a larger ecological framework, whether recordkeeping, medico-legal, or racial. By performing such work, archivists can assist researchers in the establishing the viewpoints being examined and acknowledging the silences. Careful readings by archivists of existing records and of context beyond institutional documentation are vital particularly when institution's past actions and decisions come under scrutiny by governmental agencies, academics, and the public.

In Memoriam: Access and Consequences

The LPH collection has the potential to serve numerous users for commemorative, genealogical, and academic purposes. Questions remain about the implications of the use of records as evidence specifically for social justice purposes, which broadly construed, is activism that strives for resource equity, frameworks for understanding oppression, or means for individuals and communities to represent themselves to a broader community and to present their own viewpoints in regard to their relationships with hegemonic institutions (Dunbar, 2006). In my interviews with LPH administrators, they noted the careful balance that they must maintain between their personal interest in the institution's rich history and their professional support of LPH's ongoing operation. If the archival collection were transferred to the state archives' custodianship and made available today, the archives' 75-year rolling access policy would allow the public to view the registers

and minutes through the 1930s.[60] Names of individuals to be sterilized were listed in the hospital board minutes by this time.

By providing a window into the early medical procedures performed at the hospital and other daily institutional activities, the LPH collection could be a serious legal liability to the hospital's reputation and continuing operations, and serve as evidence the state's past decisions about sterilization (e.g., North Carolina's ongoing restitution efforts). Access to the records could also be a catalyst for the state government to acknowledge its predecessors' participation in a nation-wide, decades-long movement to control minority groups through legalized surgical and pharmaceutical procedures. Efforts to memorialize LPH's former patients (beyond the cemetery marker) and to provide them with identities and voices could be an additional consequence. Any of these scenarios is possible, depending on the current climate of the state government and the efforts of researchers and patients' descendants. As an archivist scholar (Danielson and Eppard, 2013), I can envision the potential impacts of the collection on multiple stakeholder communities as well as the role archivists can have in the shaping of its reception. I address the former in this and the next sub-section, and the latter in the conclusion.

I look to two other mental facilities, the still-active St. Elizabeths and the defunct Crownsville Hospital, to illustrate efforts to manage historical mental health records and the potential consequences of making such records more widely available. For St. Elizabeths, the records available for access is both limited by what was preserved by the hospital and what is viewable under the U.S. National Archives and Records Administrations (NARA) access policy. For Crownsville, a relative lack of records management of its historical records in the past has contributed to a current governmental

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[60] Cf., the 72-Year Rule (1978), which prohibits the release of personally identifiable information from the decennial census for 72 years, except to the individual named in the record or the legal heir. The National Archives opened the 1940 census to the public in 2012.

push for institutional acknowledgement regarding the improper treatment of patients in the past and for the formation of coalitions to advocate for the identification and remembrance of the dead. Based on the examples of these two hospitals, I contend that legal access limitations and a paucity of surviving inactive records make it difficult for longitudinal and in-depth investigations into institutional histories. In order to achieve a public understanding of LPH's role in American history, the people that the hospital affected, and the cultural climate that the institution worked within, a long-view approach is imperative for the preservation of and eventual access to LPH's existing historical hospital records.

Near the end of Rebecca Skloot's popular nonfiction account of Henrietta Lacks, the Black woman whose cancerous cells were reproduced in labs and used for countless medical studies long after she died and without her consent or her family's knowledge, the author goes to Maryland's historically African American Crownsville Hospital with Lacks' daughter, Deborah, in 2001 in order to locate some of Lacks' medical records. They are directed to Paul Lurz, Crownsville's director of performance and improvement. Since the 1960s, Lurz personally collected and saved any historical hospital documents that he found to be of interest; he is not, however, a records manager or archivist and noted to Skloot, "I wish we had an archivist." Prior to Lurz's employment at Crownsville, most of the early records were destroyed in the 1950s because they were contaminated with asbestos and the hospital did not want to attempt to preserve them. The small amount of remaining old medical documents (just a "stack," according to Skloot) were in poor condition: "They were warped with age, coated in dust, and filled with thick, yellowed paper" (p. 271). Crownsville closed in 2004, but Skloot's book helped revive interest in the preservation of the remaining hospital documents and photographs. Besides Lurz, who continued to care for the records in a historian capacity, state health officials and local cultural institutions also began to take interest in the documents (*The Washington Times*, 2004; Marquardt, 2013).

The renewed focus on the Crownsville records raised public interest in Crownsville's historical treatment of African Americans labelled as mentally ill. As Lurz says in Skloot's (2010) account, "Sometimes learning can be just as painful as not knowing" (p. 271). Concern over past institutional mistreatment was exemplified by a 2013 hearing led by the Legislative Black Caucus and attended by members of the Maryland Department of Health and Mental Hygiene, the American Civil Liberties Union, and the National Association for the Advancement of Colored People: "[T]he caucus wants to learn more about medical experimentation performed on patients and what role the government played in deaths at the hospital" (Associated Press, 2013). As a result of the hearing, the state's governor called for an investigative team composed of a state archivist, two General Assembly representatives, two mental health department personnel, a former patient or family member, and a former Crownsville employee. The intention of the team, whose work is ongoing, is to uncover incidents of institutionally sanctioned mistreatment of patients, to identify the bodies in unmarked and numbered graves in the hospital's cemetery, and to set up a memorial for the deceased. The focus and tone of the investigation appears to be one of remembrance. As Maryland state delegate Barbara Robinson said, "I really want the public to know what happened and for us to use this as a teaching model. You can't change the past, but you can learn from it" (Loricchio, 2013). Robinson's measured public response points to her political acumen, in that she acknowledges social injustices in the past while distancing her state government from previous administrations' complicity in any activities involving patients that would now widely be considered acts of abuse or neglect. Crownsville and LPH of course differ in that the latter remains open and a state-led investigation into that hospital's treatment of its patients is less likely to occur because of the potential public and legal repercussions for the state. The formation of an LPH archives is thus a politically delicate situation and speaks to the potential for Trouillot's second and the third moments of silence: the formation of the archives and the recall of historical records.

Whether from unintentional institutional neglect or the intentional destruction of inactive records, there are few surviving historical mental health records, especially for African American patients. In addition to Crownsville's scant collection, St. Elizabeths preserved only a portion of its records. At St. Elizabeths, which was a federal hospital until it was transferred to the District of Columbia in 1987, patients' files were not microfilmed as they were at LPH. Henry A. explained, "The decision was made sometime in the early 20th century to only keep the case files of patients who were admitted in years ending in zero and in five." The finding aid indicates that the bulk of the case files ranged from 1855 to 1950.[61] Research from the existing records have confirmed that, along with other non-Caucasian patients, African Americans institutionalized at St. Elizabeths experienced harsher treatments and worse facilities than those of their White counterparts (Gambino, 2008; Otto, 2013). Henry A. noted from his research experience, there appeared to be a gap in the case files from roughly 1940 to 1970, the reason for which is unknown. Therefore, NARA, which is the designated repository for St. Elizabeths' records, is missing what Henry A. describes as a "significant number" of files for individuals who were institutionalized at the hospital. Besides the records that never made it to the archives, researchers who wish to use St. Elizabeths' historical records are further hindered by federal, state, and hospital-mandated privacy restrictions.

Like many government archives with medical records holdings, NARA has a 75-year rolling restriction of private health information. In our interview, Henry A. described his attempts to gain special access to the records less than 75 years of age, which required approval from the St. Elizabeths' institutional review board. The process to receive institutional review board approval for access to records that are protected under HIPAA's Privacy Rule or state regulations remains a roadblock for social science and

[61] http://www.archives.gov/research/guide-fed-records/groups/418.html

humanities researchers in particular. While Henry A. found that St. Elizabeths' archival and library staff were very helpful, he described to me a dissonance in the expectations of the hospital's research review board and what he had hoped to accomplish. His experiences with the St. Elizabeths' review board mirror my own with the LPH research review committee to get approval to interview the hospital's personnel. Both Henry A. and my interactions with hospital boards highlights the challenge for social scientists to explain their proposed research in a manner that is understandable to another community of practice, i.e., medical professionals. Although Henry A.'s proposal "wasn't rejected" outright, the board still hesitated in approving his access to records that were less than 75 years old:

> They had questions. I think they just didn't fundamentally understand that I wanted to write a history of the hospital and the patients of the hospital so they had some questions that were more along the lines of if I actually wanted to do as if I was doing some active research.

Based on Henry A.'s description of his interactions with the St. Elizabeths' board, that hospital's research review group is similar to the one at LPH in that it also receives research requests that are overwhelmingly for quantitative epidemiology studies and not qualitative social history research. In our interview, Henry A. called the former "active research" for current developments in medical practices as opposed to historical research for non-medical fields. Rather than continue pursuing his request with St. Elizabeths, which had been ongoing for four years, Henry A. decided to stop in order to focus on completing his book manuscript.

In our interview, Henry A. cited Jonathan Metzl (2009) and Matthew Gambino (2008) as notable exceptions to social scientists being unable to gain access to restricted health information. He suggested that Metzl and Gambino were granted permission to the information because of their medical backgrounds. Henry A. said, "I don't know if IRBs of institutions are just more inclined to accommodate people who are coming from similar background or if they are just a little more adept at navigating the process or a little more persistent in navigating the process than me." I speculate that is the reason for

Metzl and Gambino's success with review boards is because medically trained researchers understand the hospital environment, the shared language of medical personnel, and the norms and expectations of the biomedical sciences. In other words, they have the right social capital; Metzl and Gambino have not only the personal and professional connections within the medical world, but also the socialization to convey their proposed research using language that is familiar to the board's members. For my own research, I benefited from having several cultural brokers with medical credentials to help me navigate the social hierarchies at LPH.

If and when humanities and social science researchers are able to gain access to archival mental health records, their negotiation to balance their research goals with the legal and ethical considerations for patients' privacy continues with their interactions with the records themselves and, by proxy, the decedent record subjects. Cezary Domanski, a psychologist and science historian at Maria Currie-Sklodowska University, identified and wrote about Louis Victor Leborgne, a man in 19th-century France who lost the ability to speak, was institutionalized, and then upon his death, was dissected by Dr. Pierre Paul Broca in 1861. Domanski's historical research provides insight into a previously obscure aspect of the case: the identity of the person who was autopsied in a famous medical study. He argues, "A patient is not an object. Every person deserves respect" (Ruane, 2013, p. 20). While Domanski advocates the sharing of the histories of the dead in order to memorialize them, the public provision of such intimate and specific details about patients – even individuals who died over 150 years ago – remains uncertain territory for scholars who are focusing on American patients and must negotiate a different set of cultural norms and legal expectations.

In order to maintain patients' privacy, some scholars in the U.S. use composites of patients for their case studies, which works well for protecting individuals' identities but can compromise academic rigor. Henry A. again cited the work of Metzl (2009) in particular, who produced vivid narratives of Ionia State Hospital patients' lives that are amalgams and thus "doesn't allow for anyone else to come to follow him to check his

work." By not providing full last names, Henry A. took a different approach to giving a degree of anonymity to his research participants. He said, "One of the things that I do, even though I don't have to do it, I've decided to not disclose the full identity of any patient who I refer to in my book, even going back to the mid-19th century. Everybody, I just use their first name and the first initial of their last name." Guaranteed anonymity is of course impossible with enough resources and effort; as long as access is granted to individually identifiable health information (e.g., through the modified Privacy Rule), there is always a risk of unwanted exposure.

The intellectual and emotional impact of opening formerly closed and potentially sensitive health records does not begin and end with HIPAA. The actors of archival record ecologies – the subjects and their families, the users, and the custodians – are connected by the records and through the discourses about the objects' continuing value. The wider availability of the LPH archival collection than its current access status (restricted unless approval from the hospital's research review board) would be a major contribution to the existing corpus of archival resources on African American mental health. It will also garner more public interest in LPH and its history, for better or for worse. In the next sub-section, I focus on how archival engagement with the LPH records has the potential to lead to imaginative heritage work, community-building, and the creation of new documentation for otherwise silent actors.

Shared Records, New Perspectives

In Terry Eastwood's (1992) social theory of appraisal, he suggests that contemporary usefulness is a collection value that goes beyond evidential value, and implicates public memory. Richard Cox (2004) elaborates the notion of contemporary use by saying that "archives are a symbolic way station on the road to a collective memory" (p. 234). He characterizes collective memory as constantly in transformation, and contrasts it with historical memory, which does not depend on the responses of individuals to the past**.** Official records can serve as the tools to form and legitimize

collective memory. Jeannette Bastian (2003) calls this process commemoration. The archival endeavor of building commemorative value has the potential to encourage collective memory across communities and bring them in conversation with one another.

To conclude my discussion of the potential ongoing value of the LPH records as archival resources, I continue with findings from my interview with the social historian, Henry A., in combination with the works of scholars from archivy and sociology that address the interpretation and repurposing of inactive institutional records for community-building and to assist minority groups in the telling of their own stories. First, I discuss how scholars of historical minority experiences can analyze archival health records in ways that were not intended by the record creators in order to produce new discourses that challenge conventional notions of record subjects being powerless and unheard in official records. Then I examine commemoration in the context of community-driven archives and archival activism to be inclusive of as many perspectives as possible on historical activities, relationships, and identities. Looking beyond institutional remembrance, I argue that the development of public or collective memory for an institution such as LPH can be beneficial for the hospital's ongoing presence in the local township and to address the hospital's past roles in the state. The creation of a digital or physical place for members of the LPH archival community to contribute their own stories, contextualize different time periods throughout the hospital's history, and add their own documentation to the existing institutional records collections can open to the public the rich but heretofore largely unstudied history of the hospital.

Scholars can perform alternative readings of records after they come to a better understanding of the context of the records' creation. Harold Garfinkel (1984) hints at the potential for researchers to construct medical records in new ways, through readings and reuses that cannot be anticipated by record creators. He suggests a playfulness that comes into reading clinical records for either medical or non-medical purposes. For the clinical reader, "The documents' meanings are altered as a function of trying to assemble them into a record of a case" (p. 205). In a footnote, Garfinkel says that archival scholars can

similarly employ "an *ad hoc* strategy for collection and retrieval" in order to encourage "imaginative play" in their research (p. 206). Henry A. echoed Garfinkel's idea when he proposed in his interview that a "more imaginative readings of case files" is possible that looks at the discursive environments of the files' production. Recall Stoler's (2009) reading of the Dutch East Indies records to postulate about the colonists' epistemological anxieties, as well as my own interpretations of the early LPH register categories in which I construed a hospital recordkeeping environment where medical personnel struggled to align their observations with the disease classification developments in their discipline. Diagnostic decisions in early health records do not necessarily reflect the socio-cultural complexity of the situation. By first contextualizing the situation in which records were created, scholars can then perform readings that construct the perspectives of the actors who were part of the documents' ecology.

As part of his forthcoming manuscript, Henry A. makes the argument that, in addition to reading the St. Elizabeths records for the voices of the dominant actors (e.g., the medical personnel), he has also been able to examine voices from the patients. For his research, Henry A. focuses heavily on case files as his primary source. In the 19th century, these files consisted mostly of correspondence between hospital administrators and patients' families, rather than medical documentation:

> Some might even have letters that were written by the patients themselves, so those are really rich resources for me, just getting at the lived experience of these patients in the hospital and how they perceived their institutionalization, how their family members thought about their institutionalization, and how they exercised their own agency at requesting that they be allowed to take them home for a short period of time, and returning them to the hospital.

While these patients had relatively little control over their care and treatment, Henry A. saw some institutionalized individuals assert their agency in other ways, such as expressing their opinions to their families about being hospitalized and helping to dictate when they went on furlough. If we recall the goals of social justice activism, Henry A.'s archival research contributes to the creation of frameworks for understanding institutional

oppression and, through Henry A.'s interpretive lens, the construction of identities and viewpoints of individual African American patients.

In addition to access to the 19th-century case files, Henry A. also had use of the unrestricted portion of the 20th-century case files from St. Elizabeths. With the implementation of the modern case file, the hospital produced records that now provide Henry A. with a better idea of the relationships between patients and medical personnel, and specifically the resistance and exchanges of differing cultural beliefs:

> When you get into the 20th century and you start seeing more of the typical clinical file, what was, I would say, the most productive file for me, the one that was the richest, was the one that had very detailed documentation of the interaction between the clinical staff and the patient, so the interviews that they conducted with the patient, their observations of the patient's behavior, those kinds of things, because that was where I was able to get out, okay, how were these patients existing in the hospital. How are they resisting their institutionalization if they are resisting? How are the observations of the clinical staff members themselves being shaped by these larger preconceived ideas about racial difference?

The case files allowed Henry A. to construct his argument that some African American patients expressed "folk epistemology about disease" that cannot be easily classified under psychiatry's diagnostic rubric. Henry A. posited that in some cases, the signs of illness attributed to African American mental patients (e.g., hallucinations as indications of psychosis) could also be read as markers of socio-cultural performances by the patients:

> [The record creators] themselves are articulating a belief that African Americans are naturally superstitious, or African Americans naturally have this continuing belief in witchcraft so they are actually struggling with that; is this person actually crazy or is this person just exhibiting behavior that is consistent with their quote-unquote primitive culture?

According to Henry A.'s reading of the files, while the patients' performativity is reduced in the records into a mental illness categorization by the predominant medical community, the St. Elizabeths medical staff nevertheless expressed uncertainty about their own classificatory work. The etiological doubts seen in the case files are a

continuation of the "supposed cause of lunacy" categories seen in 19th-century patient registers. By looking at the 20th-century case files for instances of discursive resistance and disjunctions, Henry A. could begin a social history dialogue that has not been seen before: the institutional records' framing of African American patients and their experiences at St. Elizabeths in conversation with Henry A.'s contemporary constructions of patients and staff members' perspectives.

Henry A. was able to interpret the historical etiologies of diseases that St. Elizabeths' personnel attributed to patients through an alternative lens – i.e., the patients' culturally based perspectives – by first learning the contexts in which the records were made and viewing the case file as a site of interaction between dissimilar social discourses, that of African American patients and of the White-dominated field of clinical psychiatry. Throughout the interview, he demonstrated his knowledge of the record-creating situations, including the format of the records, the types of information being recorded, and the progression of recordkeeping practices at St. Elizabeths over several decades. Henry A. emphasized the need to view the records initially from the perspective of their creators: "You always have to read them a little carefully because it's obviously being written by the clinical staff itself." By better understanding the original role of case files within the hospital environment, he could then extrapolate the patients' voices from medical documents:

> I feel confident looking at these sources and in looking at these sources that I'm able to get a sense of how [the patients] get interacted with the clinical staff and how they thought about their own institutionalization, how they thought about their disease, how they thought about their illness.

Henry A.'s assuredness in his ability to interpret patients' perspectives based on clinical records points to the potential usefulness of contextualizing records within a specific institutional collection and within a particular recordkeeping environment. Similarly, I was able to construct the pervasive yet implicit role of LPH records in the management and control of the hospital's staff and patients by conducting a longitudinal analysis of the hospital's record ecologies. For social historians, such as Henry A., having an

understanding of how inactive health records fit within an institution's functions and workflows allows them construct new or historically marginalized perspectives. Furthermore, they can produce readings that are at once imaginative and engaged with the viewpoints and situations of the record creators.

A digital archives medium is especially suited for archives users to develop their own organizational schema to "read" institutional records through different lenses (e.g., perspectives or themes). A digital archives for the historical LPH records would allow members of the public who would otherwise not have easy access to the original documents to search, view, and use the hospital's records. The record managers and archivists can maintain the print collection according to the principle of respect des fonds and reflect this arrangement in the structure of files in the digital archives, so that record users are able to understand a digitized object's provenance within this particular bureaucratic institution and how the item was utilized in everyday activities. The ability for digital files to be duplicated and moved with ease also allows users to develop thematic connections among digital objects that differ from the relationships established by the documents' original institutional functions or creators. While developing these digital threads among objects, the user could potentially return to the several other possible fond structures offered by the collection archivist or other users if the digital archives allows for the preservation of multiple arrangements. Wider access to the records through a digital medium contributes itself significantly to the pluralization of viewpoints regarding the records and the hospital. Having access to the digital records *and* additional user-generated metadata and records would promote further creative readings of the documents.

Although it is yet to be seen if LPH patients' information will be available digitally and thus be useful especially for genealogists and descendants of patients, the records that do not reveal individually identifiable health information can nonetheless be valuable to those interested in the institution itself. For example, the local building committee minutes from 1955 provided me with unexpected insight into how the hospital

medically categorized patients and subsequently geographically sorted them as "classes." As part of its discussion about construction, the committee meeting minutes indicate that the LPH's patient population was divided into male and female epileptics, feebleminded, criminals, tubercular (who were isolated), and "other psychoses." Each group had its own building.

I also saw a glimpse of LPH's administration's humanity, rather than its more commonly recorded efforts to discipline and control, in the minutes from the State Board meetings. The superintendent reported in the 1961 minutes that there has been a considerable increase in the number of patients admitted to the hospital "during the recent cold weather." While he noted that most of the patients were committed "with no symptoms of mental illness," the minutes do not indicate that anyone present wished for these "old and infirm" individuals to be discharged or transferred elsewhere. Rather, the Superintendent simply stated that "double bunks are being installed to make more effective use of the patient areas or wards." It is only a brief mention in the minutes (as we know the Board meetings' primary function was to be a problem-solving venue), but the incident illustrates the charity of the LPH administration to take care of those who are not labeled as mentally ill or disabled, but simply needed a place to stay in a time of need. Record descriptions of activities that took place at LPH and of the decisions made by the administrators suggest that the hospital, in its substantial relationship with the surrounding communities, was a more socially complex actor than simply being a Goffman-esque "total institution." Whether the records in the LPH digital archives that contain patients' health information are opened to the public, the digitized collection *en masse* is symbolic of the hospital administration's and state's willingness to open records that illustrate LPH's history and to have a conversation with the public about the hospital's decisions and actions over time in regard to African American mental health care.

A publicly accessible online LPH archives will bring a great deal more exposure to the hospital and its history. Its past actions will become of interest to more than the

handful of academic scholars who have so far examined the institution without access to most of its historical records. With a digital archives, I believe there is an opportunity for archival users to engage with the historical documents and the hospital's history in ways that are not usually possible in a traditional brick-and-mortar repository. The active inclusion of other narratives as part of the digital version of the collection can be a starting point for commemorative activities. Groups, whether the hospital administrators, archival custodians, or the local community (all of whom may have linked interests), that would like to develop public memory regarding LPH can use the tactic of sharing historical evidence and previous symbols of commemoration. Objects such as the hospital's archival records and the historical road marker, respectively, are all representations of the hospital from different points of time and for different institutional purposes. They can serve as a starting point for the creation of a new collection of non-institutional records about LPH, such as oral narratives and user-donated items. These records could be integrated into the digital archives as a separate user-generated collection or as a continuation of the LPH narrative, i.e., where the official records left off and what they left out. For example, if a scholar has an interest in the workplace practices that are undocumented in the existing LPH archival records, she could conduct observations of current staff members. Or if a local historian wishes to have a better understanding of the experiences of former LPH patients' family members, he could seek out interviews through his community connections. Such additional content and contextualization complement the official records and the commensurate institutional perspective on hospital activities. The addition of other viewpoints add value and focus on the hospital's social, political, and economic role on the state, and especially on the surrounding communities.

The collecting of multiple and diverse perspectives on life within and near the hospital through commemorative work and public memory activities could begin discussions among the LPH administration, the staff, and the local community about the hospital's social legacy. Based on my interviews with hospital staff members, I found

that, while there are persistent tensions regarding the perceived historical role of the hospital in segregated practices and the mistreatment of African Americans, these uneasy emotions have never been fully articulated among the staff, with administrators, or in a more public venue. If you recall, the fourth potential moment of silence according to Trouillot (1995) is remembrance. When there are aspects of the past that are emotionally painful or dangerous to current relationships, individuals and groups can become unwilling to talk about particular times in history in hopes of letting the events fade from individual and public memory. Foote (2003) points to "the assertion of rights by minority groups" (p. 11) as one prominent area of American history in which there continues to be conflict over if and how the struggles of minority groups in the past should be remembered. In my conversations with former employees, I encountered resistance to talking about the sensitive subject of race and specifically desegregation at the hospital for those who were employed at the time. While we know that race relations in general were tense in the South during the 1960s, the staff members that I spoke with preferred to skim over their perceptions of the racial atmosphere at the hospital during this time period.

When I told Dennis H. that most of the former LPH employees I spoke with were not particularly forthcoming regarding problematic race relations in the past at the hospital, he astutely pointed out, "There are a number of those historical holes. Things just kind of go unsaid for a period of time. [pause] Yeah, there are a number of areas that would take some real scrubbing to try to figure out what else was going on." Perhaps not enough time has passed. Perhaps the current political climate at the central office is not conducive to retrospections on race relations within the walls of one of its facilities. And furthermore, it is unsurprising that former personnel were reluctant to talk to me, an outsider, about the subject matter. I believe inquiry into the impact of race as a social construct at LPH, or simply "scrubbing" as Dennis H. describes it, has to come from within the LPH community, whether from staff members or former patients and families, along with the full support of the administration. As an archivist, I can at least help start

the critical examination of different representations of race relations by ensuring that the historical records are preserved and become a viable resource in the future.

In this concluding discussion section on commemoration and understanding, I have examined the LPH records as archival objects. Although the majority of the inactive records continue to be under the custodianship of the hospital, negotiations about the digitization then eventual transfer of the physical collection to the archives have been ongoing among the project team, the state archives, and the hospital administration for the past several years. Based on my constructions of the LPH records ecologies over time, I better understand how the inactive LPH records continue be imbued with socio-cultural, political, and financial significance to the hospital, to the state government, and to potential users of the collection. As archival objects, the LPH records can be used to inform, harm, uplift, and bring together or drive apart individuals. Although hospital and state administrators and medical record retention and privacy laws can shield inactive records from being more widely seen, once records become available, it cannot be predicted how those records and the information that they contain will be used. The preserved records can serve as evidence of past administrative and medical decisions. They can also assist in the development of new voices and perspectives on hospital activities from actors that are silent in the U.S.' historical record.

I believe that the ideal course of action for not only the development of the cultural record but also for LPH and the state is to preserve as many of the records as possible for future access. While privacy restrictions will prevent some records from being seen for many decades, the continued existence of the records and their acknowledgement in the finding aid as part of the collection is part of the process to recognize formally the many patients who passed through LPH and the staff whose work would otherwise go unnoticed. Trouillot (1995) notes that history "begins with bodies and artifacts: living brains, fossils, texts, buildings" (p. 29). The history of LPH is inclusive of not just the official institutional records, but also the land, the architectural

structures, and the people and ideas that worked and lived at the hospital over the course of 140 years.

Dennis H., the LPH doctor and administrator and amateur historian, expressed his eagerness to see the LPH archival collection put under the custodianship of the state archives. For him, the transfer means ensuring the long-term preservation and access to historically inaccessible records. Due to the current unavailability of the records to outside researchers, the legacy of LPH for African American health care, race relations, local economics, and state politics continue to be unacknowledged and potentially forgotten. For Dennis H., the continued absence of the LPH collection in the state archives is a documentary segregation that mimics the de jure segregation of Blacks and White throughout the South during the Jim Crow years. While the segregation of patients at the hospital ended nearly 50 years ago, the LPH records are not yet fully included in the story of the state's mental facilities. The state archives is considered to be the holder of all the representative histories of the state, and the absence of a complete-as-possible LPH collection is symbolic of the state's reluctance to affirm the importance of the African American mental health care experience. Dennis H. says, "I got a tear in the corner of my eye because it's like 1964 all over again. […] Isn't it something that in 2015, we're going to integrate the archives? Isn't that interesting?"

Chapter 5: Conclusion

Mental health remains a taboo subject to many people in the U.S., and the federal and state access restrictions to medical records regarding mental health care reflect this cultural belief and the necessity to protect patients' privacy through legal means. HIPAA and the HSS' Privacy Rule help to ensure that patients' identities and personal information remain inaccessible to anyone other than the patients and their health care providers for up to 50 years after death. Many state codes for non-covered entities only allow access only after 75 years after record creation. The laws make it challenging, if not impossible, for academic and medical researchers, genealogists, and historians to view records that contain private health information. Unless private information is digitally redacted from digitized documents or non-restricted information is scraped and aggregated into large anonymous datasets, both of which are time-consuming and technologically advanced tasks when faced with handwritten documents, the bulk of historical medical records remain relatively inaccessible.

In my dissertation research, I sought to investigate the social situations surrounding a mental hospital's records in their creation, use, organization, preservation or destruction, and archival use. Recall my research questions as follows:

How have the historical records of LPH contributed to the cultural life of the hospital?

- What role did the records play in the daily work practices of the nursing staff?
- What power inequities are reflected in the records? Have the records perpetuated these inequities, and if so, how?

How can the records contribute to the cultural life of a broader audience now?

- What stakeholders, social relationships, and historical circumstances will affect record preservation, record access, and potential communities of users?

- What are the ongoing values of these records, especially given privacy restrictions and limitations of what the records alone can tell us?
- What role do archivists play in addressing power inequities?

My intent was to come to a better understanding of how hospital records can become so entwined in daily workplace activities and human relationships that they continue to be powerful objects throughout their existence in their original institutional settings and, potentially later, in archives.

In my dissertation, I examine how specific genres of mental hospital records from a single institution have changed over time in terms of how they appear and how they are and were used. Larch Point Hospital records are actants that have always been participants in the institution's daily administrative and medical operations, in that they have mediated relationships between actors and altered perceptions and actions because of their existence. The social ecologies of the records includes the many patients who have been documented within their pages, the record creators, and others who have contributed to the preservation and organization of and access to records. For this study, I focused on the social contexts in which the records existed, and I looked particularly for instances of actors using documents to support existing power structures. By examining the social ecologies of the LPH records across time, I determined that the records assisted with the discursive work of many actors, but primarily those with power. These were the hospital and state board members, the doctors, and, in the latter half of the 20th century, the nurses. The process of producing minutes and registers provided the boards and hospital administrations a means to project stability and manageable institutional growth to those both within and without the hospital walls. Still present in the record ecologies but less represented by their own voices or not heard at all are the patients, their families, and the lower ranked staff members such as the clerks and attendants. The records have affected a countless number of actors as active documents and continue to do so today as archival objects.

Influenced by the sociological studies of medical environments by Goffman, Garfinkel, Glaser and Strauss, and Foucault; the feminist research of Clarke, Hochschild, and Haraway; and the archival activism of Harris and Jimerson, I was interested in examining the social relationships and hierarchies that the LPH records mediated in the past because I believe such knowledge can inform cultural heritage professionals, legal bodies, and others who make decisions regarding the preservation and access of sensitive institutional records in general. I wanted to look at what this particular collection of documents meant to the institution in the past and to its stakeholders in the present. By focusing on the records' ecologies, I could construct a picture of the many actors affected by the records, and not just the actors who are powerful. My examination of the social worlds of the record-making and record-creating processes at LPH allowed me to understand how mental hospital documents could contribute to the cultural record and, relatedly, why they can be considered a risk to individuals and institutions. While all organizational records have potentially sensitive information that could harm the financial, social, and emotional well-being of living individuals, the LPH collection is an especially unusual and important set of documents due to the institution's role in the history of African American mental health care.

LPH has an institutional history that coincides with the rise and fall of de jure segregation in the American South and the doctrine (and platitude) of "separate but equal." I discovered quickly during my time working with the LPH records as the project archivist and as an academic researcher that the historical documents from this hospital continue to mean a great deal both politically and emotionally to hospital personnel and state officials, descendants of patients, and historians. As a result of my personal interactions with some of the actors connected by the LPH records, it became my intention to conduct my dissertation research as not only an intellectual challenge to construct record ecologies but also an opportunity to offer theoretical frameworks and practical insights that could assist cultural heritage professionals in identifying and

addressing stakeholders' concerns about the negotiations and shifting power dynamics among actors throughout the process to transfer custodianship of institutional records.

In this concluding chapter, I first discuss the major limitations of my research, especially the epistemological boundaries of a case study. Then I present the implications of my selected methodological framework and methods on archival theory and practice. I also give potential consequences of my research for the LPH project, the hospital's archival records, and its stakeholders. Based on my findings, I address the various actors associated with the LPH records. I offer practical recommendations regarding the management of sensitive institutional records, which may be applicable to similar record ecology situations. Finally, I look toward future research that I would like to undertake in order to engage other institutional record ecologies and the development of digital archives models for digitized and born-digital health records.

LIMITATIONS

The major limitation of my study is that I focus on one institution and its records. By not examining the records of other state mental facilities (whether in the same state as LPH or other African American hospitals in the South), I could not compare and contrast the registers and minutes from multiple institutions. As a result, I cannot yet address questions such as whether new record formats used by LPH were being implemented at similar times in all-White facilities or if and how hospital desegregation was discussed and applied in other states. My attention to one facility and one collection was intentional, given my time restraints, the scope of a dissertation study, and the circumstances that allowed me to have extensive access to the LPH records. I was able to immerse myself in the hospital's record environment and to study how it changed over time under a particular set of social conditions, actors, and institutional needs. Every institution and its records emerge from a unique social context, and to generalize about the social ecologies of other hospitals' records without also examining those situations would be irresponsible.

Another potential limitation in my research is the narrow spectrum of perspectives I was able to examine within the LPH record ecologies. In order to approach my research questions about the social ecologies of the LPH historical records as part of hospital activities and as an archival collection, I necessarily had to collect data from multiple sources across several eras. Indicative of the selectivity of discourses valued within a bureaucratic system, only administrative viewpoints can be found in the archival records. To my knowledge, no personal diaries or non-official records pertaining to the 19th-century/early-20th century hospital have been found; therefore, the archival LPH collection is all that remains to illustrate the institution's early history. The surviving institutional records nevertheless offer glimpses into the lives of patients as interpreted by hospital personnel, as long as the researcher applies a hermeneutic of suspicion to look for systemic prejudices. As I have argued, the records must be read in the context of their creation in order to better understand the underlying social dynamics occurring through the records, as well as the limitations of the documents themselves in what they tell us. Since one of my primary research goals was to learn about the ecologies of record creation, the chiefly administrative perspectives that I constructed from the records told me a great deal about the overt and implicit work done by the records.

Although I was able to diversify the types of perspectives regarding the third era (1955-1970) and the present day by conducting interviews with six LPH staff members, one archivist, and one researcher, my findings were circumscribed by the number of individuals that I spoke with and the number of times that I interviewed each person. Relatedly, I entered each formal interview knowing that my prior relationship with each interviewee, if any, would affect the conversation. If I had been able to speak with each interviewee multiple times, I might have gained more insight into her experiences regarding sensitive topics (e.g., race classifications in records), and we could have explored further her everyday recordkeeping practices. I would have also liked to have interviewed a larger number of current and former staff members, but I believe I was able to speak to individuals who held fairly diverse roles within the information workflows at

LPH. I talked with most of the key hospital players in the archival transition of the records as well. In terms of my recruitment of LPH interviewees, I had to exhibit some restraint in my persistence regarding whom I interviewed, especially current employees, because I did not want to jeopardize the success of the LPH archives project or my relationship with the hospital administration as the project archivist. Finally, although I could have conducted formal interviews with more archivists and researchers regarding their perspectives on the practical uses of archival mental health records and the ethics of having access to them, the archivist and social historian that I spoke with provided me with exceptional insight into the specific archival situation for the LPH records (Ann P.) and the current research on African American mental health records (Henry A.). I consider these two perspectives that I have analyzed thus far to be a starting point for future examination of the potential archival users of medical record collections, including the opinions of former patients and patients' families.

Finally, I would like to explain briefly why I did not utilize a mixed method design or one that was qualitatively driven but with auxiliary quantitative elements. I argue these methods would only have been beneficial if I had different research questions and goals. For example, if I had examined records from multiple institutions or if I had conducted a survey of digital archives or attitudes regarding health information privacy, a statistical analysis would have been informative, especially in the last case where I could have extrapolated my results to a larger population. Instead, I undertook research to understand one type of actants' social ecologies over time, and using situational analysis and critical discourse analysis to analyze and discuss my data seemed the best way to illustrate the complex relationships and the discursive work being done in those settings. Situational and discourse analyses of the records and the interviews gave me a good understanding of how and why the historical records were used in the past, the recorded perspectives and the silences, and what the collection evokes in people today.

RESEARCH IMPLICATIONS

After reflecting on the methods that I used to analyze the archival records and interview data, I believe that the implementation of similar methods by other social science researchers can be productive and allow us to perceive the discursive work of records in new ways. The methods of analysis that I employed, situational analysis and the social actors approach to critical discourse analysis (CDA), have utility for approaching longitudinal historical topics. By applying these methods to record types that appear across different slices of time, researchers can compare and contrast the actors and actants, as well as their relationships to one another, over several temporal periods.[62] The method of situational analysis to map the actors and actants involved in record ecologies was particularly valuable as a tool to visualize the relationships among all of the stakeholders. Although I did not create as many maps in variety or number as I originally intended, the process of listing the human and non-human elements involved in situations (Appendix E and F) was helpful to see the changes across eras and record types. I would recommend this approach to researchers who are interested in untangling the discursive work being done by actants and actors in a particular situation or environment. The social actors approach to CDA encourages researchers to frame the records as discursive performers, and to examine changes in formats, styles, and participants. The remainder of this section focuses on my reflections about my methodological framework as applied to the LPH records and how Actor-Network Theory (ANT) can be informative for archival practice and theory.

Although my study focuses on one hospital and one record collection, my theoretical framework has implications that go beyond LPH and can be applied to any institutional record collection that contains private or socio-culturally sensitive information (e.g., schools, orphanages, prisons). The value of engaging social

[62] Recall Figure 1, and the blue circles that represent the corpus of LPH records at different points, or slices, in time.

constructionism and especially ANT to examine hospital recordkeeping is that these methodologies reframe how we can look at the impact of hospital records and consequently how we think about the way we treat such records as archival objects. I adopted Klein and Myers' (1999) interpretive approach for my research, so that ANT became my theoretical lens to examine data and frame them within a broader context. I found that having knowledge of ANT greatly influenced my research and understanding of organizational documents as pervasive players in social situations rather than static objects used in the course of a particular institutional activity or function. By focusing on the changing record formats and types of recorded information, I have been able to discern how the LPH records work within hospital activities, alter relationships, and determine the way information is recorded and transmitted. I argue that thinking of records as active participants in social ecologies can alter how custodians and other stakeholders of hospital records engage the documents; the records are not so much tools but objects imbued with power, meaning, and agency that are capable of causing social and epistemological shifts that are greater than the intentions or efforts of their human creators.

Through the lens of ANT, I found the often dichotomous characteristics of privacy laws and regulations to be insufficient in addressing the social complexities of archival health records. For instance, the Privacy Rule imposes temporal boundaries for restriction and access; the current restriction on private health information until 50 years after death is an inflexible limitation. Furthermore, HIPAA and the Privacy Rule address only the privacy of the patient and, to a limited extent, her relatives; they do not account for other actors involved in the recording of medical information, such as nurses who may be named in the documents or the clerks who typed the records.[63] In addition to the actors involved in record ecologies, the laws and regulations also do not consider the

[63] Cf., the Family Educational Rights and Privacy Act (1974), which protects the privacy of student education records, but does not apply to the records of educators.

variety of record genres and formats in which individually identifiable health information may appear. HIPAA emerged from the growing use of digital records and their electronic transmission and is most obviously applicable to patients' digital records, but non-born digital records such as bound registers and microfilmed case files are particularly difficult to make accessible due to the multiple patients named in them.

By focusing on the discursive work of records as actants, I better understood why laws pertaining to the restriction and retention of medical records were problematic, and will continue to be contentious, to different collective actors. As hospital records move into the archival environment, they endure as representations of a facility's efforts to demonstrate responsible decision-making and actions to administrative superiors but, as historical artifacts, they also can be used as evidence for a different kind of accountability – social justice. Although HIPAA and similar state laws are necessary and their broad restrictions are unavoidable, hospital records are far more dynamic social objects than these legal boundaries suggest, and the legislative laws and their regulatory counterparts cannot account for the varied attitudes toward health information privacy held by different actors within record ecologies.

ANT helps direct our attention to how records reach into every aspect of, and occasionally drive, hospitals' activities. While people create records, the records in turn help maintain the status quo and strict hierarchies that are commonplace and expected in total institutions. The study of record ecologies brings focus on the records themselves as objects, or actants, contributing to and controlling the movement of information. Records participate in the imperfect social reproduction and reinforcement of institutional structures and powers. They affect many different actors over time, including implicated ones who often have no agency (e.g., patients) or who are integral to record creation but are not seen in the records themselves (e.g., clerks). The LPH collection, while by no means representative of all institutional collections, demonstrates how records can take part in deeply rooted social inequalities caused by racial and professional hegemonies. I implemented an activist research design to consider the many silent actors involved in the

ecologies of these objects and to reveal purposefully the inequities performed by the historical records. My intention was to bring attention to the idea that expanded archival participation, in terms of a broader spectrum of users and of record uses, can give minority groups the opportunity to express their own lived experiences.

Unlike postmodern archival research that focus on the creation of community-based archives, my work involves record subjects who may lack agency over their bodies and minds and, subsequently, their documentation. These subjects are not active participants in the discursive work seen in the records, but are nevertheless part of record ecologies. While the post-custodial trend in archival practice and theory often calls for a record collection to be transferred to a community of record subjects, it is not always feasible to do so. In the case of LPH, by state law, the collection must either remain in the hands of the creating institution or in the custodianship of the state archives. As I have argued, the state's physical and legal custodianship of the LPH records serves as a necessary mediator for public access to private health information. Furthermore, if we consider the LPH record subjects, many patients seen in the archival records are deceased, and the surviving former patients and descendants have not joined together yet to take symbolic control of their records. In order to expand access to sensitive records to a dispersed group of stakeholders and to gather diverse perspectives in the archives about institutional activities and the groups of people that participated in and were affected by them, the expanded roles of the archivist and digital technologies become critical.

This study suggests that the goals of archival activism for institutional records with sensitive information differ from those one might see in community archives situations. Rather than serving primarily as consultants in the development of an archives, archivists may need to take on other responsibilities to ensure a balance between access to and protection of institutional record information. For instance, an action might involve archivists and other heritage professionals advocating federal and state regulations that allow the custodians of institutional collections to have greater discretionary power in determining individual and group access rights to specific sets of

information. The ability to have this decision-making power, however, would need to continue to be bounded by the law in order to mitigate some of the professional risk of mediating who receives permission to gain access and when to sensitive records. States would need to mandate the creation of state- or repository-level rubrics that define the levels of access to different types of records; ideally, archivists would have a substantive role in determining the criteria for record access.

Another archival action can include the development and governance of digital technologies that provide tiered levels of access to digitized institutional documents. One of the primary goals of the projected second phase of the LPH archives project is the development of such a digital archives. Records containing private health information protected under the law would be accessible only by current LPH personnel. Patients' families with the proven genealogical credentials would have digital access to records pertaining to their relatives. Researchers with permission from a Privacy Board would have some limited access. As the gatekeepers to legally protected information, archivists are obligated to shield patients' private information from the public. A digital portal may be the ideal venue for making as much information from a sensitive collection available within the confines of the law or a stricter code of ethics.

With the development of an online archives of digitized institutional records, archivists also can become the advocates for the digital reunification of hospital records with records subjects and other silent actors. If activist archivists seek to diversify the recorded perspectives on a particular institution, they can pursue for themselves or facilitate the recording of oral narratives from surviving staff members and record subjects to include in a separate collection linked to the institutional collection. With digital technologies, archivists can maintain the context and structure of the institutional records within their original functions and activities, while also joining institutional collections with diverse community perspectives in order to bring a more holistic understanding of an institution's socio-political impact and character. Archivists of institutional collections are the actors who can bridge the communication divide between

state organizations and silent actors in record ecologies. In doing so, the archives transform into a site of negotiation and ongoing dialogue among record stakeholders regarding the power inequities found within the institution and its records.

RECOMMENDATIONS AND FUTURE WORK

LPH is a singular institution in its state in terms of its impact on African American mental health care, and has very few peers in the nation. As soon as I began processing the collection, I had a strong sense that I was working with documents that needed to be seen, studied, and written about. The historical records that I processed provided insight into the hospital's remarkable history and purpose, while at the same time demonstrating how the hospital worked within and resembled, at least organizationally, a larger network of state mental facilities. Due to the hospital's roots in African American health care, its administrators and patients have had to have endure fewer resources, more social stigma, and greater political and public scrutiny than the other mental facilities in the state. While LPH has always been cooperative and communicative with the state government, I also found the many iterations of LPH administrations throughout the history of the hospital to be aware of their unique situation during the lengthy segregated era: to be in charge of the institutional mental health care for the state's African American population. This awareness of difference, felt also among the staff, patients, and the local township, helped foster an insular hospital community with its own mix of cultural influences, norms, and expectations. The distinctive cultural and institutional qualities that makes the LPH records valuable as historical artifacts are also what has made the records more difficult to access.

When I began as the archivist for the LPH project in the summer of 2010, I did not realize that the LPH records would become the focus of my dissertation research. At the time, I just knew that I wanted to help with the potentially urgent preservation situation at the hospital, and that the dilemma pointed to an interesting custodial problem. I had assumed that a longstanding state institution would have a clear record retention

and disposition schedule in place, but what I came to realize is that such a relatively modern timetable does not apply to older hospital records, and the state codes leave it to the archives to negotiate with state facilities on a case-by-case basis. Furthermore, I learned that a collection transfer plan is useless without consistent and deliberate organizational and person-to-person relationships between the hospital and the state archives. The development of candid long-term relations are especially important when hospital personnel continue to remember a history of institutional mistrust and disappointment in the state administrative bodies.

The archives project continues at the time of this writing, including policy-building on the access and retention of historical mental health records and the development of a digital archives that can be adjusted to changing privacy restrictions. As I have noted, the historical documents are not yet in the state archives, and I intend to continue to help facilitate this transition and to better understand the social complexities of the transition in which institutional records become archival ones. In my discussion of the 2013 revisions to the Privacy Rule earlier in the dissertation, I noted that the modified federal regulation violates two privacy principles because it permits public access to an individual's health information 50 years after the person's death. The original version of the Privacy Rule did not allow access to such information kept in covered entities into perpetuity, regardless of when the record subjects died, unless researchers received permission from privacy boards. One of the privacy tenets is that the record subjects must first give permission to others before their record information is used, especially for new and unintended purposes. The second tenet is that record subjects must be *opting into* rather than *opting out of* allowing others to access and use their private record information.

While the revised Privacy Rule clearly breaches at least two fundamental privacy principles, I have attempted to demonstrate in this dissertation that the eventual opening of formerly closed mental health records is necessary in order for different actors (e.g., state administrators and the descendants of record subjects) to address historical social,

economic, and documentation inequities. I have argued that the preservation of and access to mental health records is critical to the development of public memory regarding a highly stigmatized environment. Access to historical mental institution records can also result in the creation of new records by members of minority groups who did get to actively participate in the creation of or be represented by institutional records. Finally, the federal permission to open records without the consent of the record subjects allows us to examine the concept of privacy, especially what it means in the context of historical institutional health records. Privacy can be viewed as a shared right among a group, such as a family, and not just an individualistic right. Therefore, although it is too late to receive permission from the record subjects whose health information is now available to the public, it is possible to engage with patients' descendants to discuss their viewpoints about the release of their ancestors' records. Researchers can also work with the record creators (e.g., clerks and nurses) to determine how the makers of records feel about their labor potentially being seen and used by others outside of the records' original recordkeeping purposes.

Over the several years that I have thus far been a member of the LPH archives project, it has become apparent to the team that other historical mental facilities are facing similar questions of how best to balance patients' privacy, institution's (if the facilities are still active) and states' wishes, and the interests of prospective archival users. My own research has led me to create several recommendations specifically for the LPH archives project, which could be adapted for other situations involving the transfer of an institutional collection with sensitive information and the development of stakeholders' involvement and access. Recall the social worlds/arenas map for the LPH archival hospital records (Figure 5), which shows the actors implicitly or explicitly involved in the custodianship, ownership, and use of the historical collection. While these stakeholders share interest in the hospital's archival records, their concerns are diverse. The individuals that make up each collective actor also have their own agendas and opinions. Based on my investigation into the record ecologies of LPH, I have come to a

more informed understanding of how records have participated and affected everyday life at the hospital, and continue to be actants of importance to many actors. In the follow list of stakeholders who are a part of the archival LPH record ecologies, I provide brief recommendations for each collective actor regarding the considerations and actions that can help lead to successful negotiations between and possible collaborations among stakeholders in regard to the preservation of and access to inactive institutional records:

- LPH administrators and hospital records managers: Despite weak past relationships with the state archives, the hospital administration can contact the state archivists now to request a tour of the state archives' facilities for LPH personnel and a presentation on the archives' most recent access and retention policies. The current LPH records manager needs to be included in communications among the hospital administration, state archives, and LPH project team in order to keep abreast of the status of the historical records transfer. The records manager, who is one of the primary users of the archival records at the hospital, should be included in all discussions with the LPH administrators and the state archivists about the level of access that hospital personnel will have to the records once the documents are under the archives' custodianship.
- UT project team: As the team anticipates the second phase of the project to develop the digital archives, it is important that the team considers the privacy requests of record subjects, especially given the Privacy Rule's encroachment on several privacy principles. In order to better understand these privacy wishes, the team can conduct a study involving former patients and patients' families. As the LPH digital archives comes to fruition, the team will need to examine the different archival needs of the Web site's users. The team can conduct assessments of the value of the Web site to the public and to staff; such evaluations will be especially important if the project is to serve as a touchstone for other institutions with sensitive historical records. Furthermore, the team must

continue to build strong relationships with both the state archives and the hospital, and facilitate increased communication between the archives and the hospital to encourage the collection transfer. The team can collaborate with the institutional stakeholders to develop small exhibits at the hospital, the Department of Mental Health, and the state archives that go in depth into aspects of the hospital's history (e.g., treatment of tuberculosis, nurse training programs, impact of the hospital on the local economy in the late 19th century). They could also work with the hospital to hold luncheons for current and former staff members to talk about the project's progress and share historical findings. Any interactions that hospital staff members have with collection materials can help bolster administrative support for the social and commemorative value of the archival records. Casual gatherings with retired personnel could also spur interest in the contribution of oral histories to the digital archives.

- State archives: I suggest that its archivists be more active in contacting the hospital's administration, record managers, directors, and general staff to ease any concerns or doubts about the transfer of the collection. It has been several years since the last face-to-face meeting regarding the archival collection, and there are many new key actors. Ideally, the archival staff can also work more closely with the UT team to identify potential users, users' needs, and fonds structures for the digital archives. Finally, archivists who manage any kind of records with sensitive information should also stay up to date about HIPAA and other information privacy laws in case they will affect the policies of the archivists' institutions.
- State Attorney General office and Department of Mental Health: Both the Department and the Attorney General office's primary role in the LPH archival record ecology continue to be the risk managers for the hospital, and specifically the protection of sensitive record information that could be damaging for the state. Their political concerns are most likely the greatest hurdle to making the collection more widely accessible via digital means. The heads of the three

primary actors in the digitization project (the hospital, the UT team, and the state archives) will have to continue to consult with the Attorney General and the Department of Mental Health through consistent and documented communication before deciding about the project implementation.

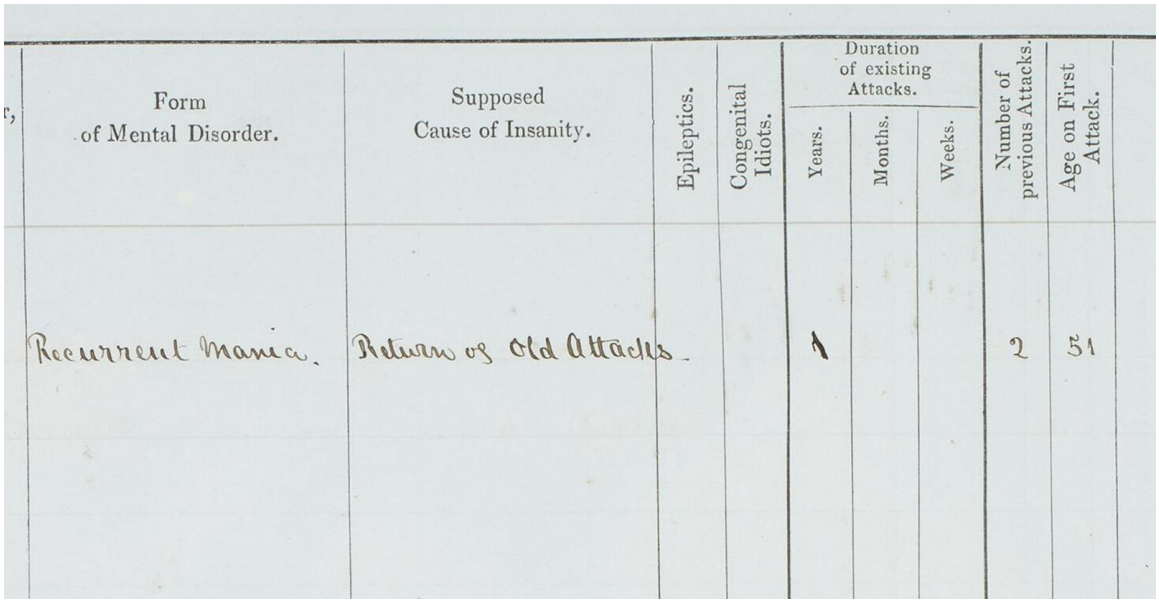
- Former patients and patients' families: The UT team should make efforts to contact some former patients and their families to discuss the digital archives plans and gather their opinions regarding what materials are made available and to whom. If amenable, ex-patients and relatives can contribute to an oral history of the hospital. In addition, a clearly written website that provides information regarding medical record privacy and access laws for the state would be useful for those who have genealogical connections to former hospital patients and an interest in the archival records. If the website included the laws and regulations for other states, it could also serve as a hub for record inquirers to find and contact the records managers and archivists within the U.S. who oversee institutional health record collections.
- Local historical societies: These groups and other leaders in the townships surrounding LPH are the potential mediators and cultural brokers that can bridge the other actors, including the implicit actors, in collaboration with one another to build a community archives. In the case of the LPH collection, however, they do not have much political influence among the bureaucratic entities. Therefore, it is the responsibility of the UT team, in conjunction with archival advocates among the hospital staff, to reach out to these societies regarding the socio-cultural value of community-contributed materials to a digital archives (since a print collection included in the state archives is less feasible). The historical groups can contact individuals who are open about their connections to the hospital, whether as patients or staff, and may be willing to contribute personal documents or testimonies to the digital archives.

- Big data management: The feasibility of creating a full-text search function or automated redaction for digitized handwritten records will continue to be the greatest challenge for information professionals who seek to make historical records with private information more widely available digitally. These experts will need to continue working with the custodians of hospital record collections in order to not only have access to the original materials, but also to understand these institutions' needs to restrict access and their digital infrastructure capabilities. The UT team is in charge of the LPH digital archives development, but the state archives may take over the preservation and storage of the digital files in the future. State and federal records managers and archivists will increasingly have to care for born-digital health records. The management workflows for large numbers of digitized health records, while somewhat different from the complexities of overseeing born-digital files, nevertheless requires a similar proactive and diligent stance toward item-level care.
- Patient and staff advocates: Although patients and staff are two distinct collective actors, they can both be silent participants in record ecologies. In the archival environment, patients and staff who are represented in the records may no longer be living, but there are many actors who can and do serve as their advocates, such as research review boards, current hospital administrators, archivists, mental health non-profits, and family members. Several of these advocates are already part of the conversation in the LPH project, and their active participation especially in the early planning stages of an archival endeavor is critical to ensuring that the identities of individuals who cannot speak for themselves are ethically handled, regardless of the current federal and state legislation and regulatory laws that may allow information about those silent actors to be revealed.
- Potential users: The future users of the LPH archival collection will be varied and cannot be predicted. Genealogists and academics, however, have already shown

interest in the collection. Social science and humanities researchers need to be mindful of how they communicate with medical institutions holding historical records. The ability to speak across disciplines to medical personnel, governmental officials, and other bureaucratic administrators is important if academics from these fields wish to convey successfully the potential societal values of their work and their ethical standards. In terms of potential emergent users of the collection (and prospective contributors to a community-created collection), such as former patients and retired staff members, all of the major collective actors involved in the archival record ecology will need to collaborate in order to reach these groups.

In addition to continuing work on the LPH project and working on the development of the digital archives, privacy policies, and outreach to implicit record ecology actors/emergent user communities, I have several ideas for future research. I may use grounded theory from an interpretivist position to look at data from at least one other mental institution. This type of qualitative research is developed inductively from a body of data acquired by a participant-observer, and usually involves multiple case studies to allow for comparison (Clarke, 2005, p. 170). By comparing multiple sites and contexts, I can begin to provide broader findings and make generalized recommendations about preservation and access to historical health records as cultural heritage materials. In addition to looking at the record collections from the other hospitals from in LPH's home state, I can look both nationally and internationally. An example of another mental institution whose record formats and types that I could examine in-depth and compare with those of LPH is the Ticehurst House Hospital, a private asylum in East Sussex, England. The entirety of the hospital's collection (1787-1975) has been made available online by the Wellcome Library as part of its ambitious "The Asylum and Beyond" digitization project (Hilton, 2013). Even a cursory look at one of the British hospital's early registers in Illustration 15 shows the similar etiological uncertainty (e.g., "Supposed

Cause of Insanity") that I observed in the categories and handwritten entries of the 19th-century LPH registers.



Form of Mental Disorder.	Supposed Cause of Insanity.	Epileptics.	Congenital Idiots.	Duration of existing Attacks. Years.	Months.	Weeks.	Number of previous Attacks.	Age on First Attack.
Recurrent Mania.	Return of Old Attacks.			1			2	51

Illustration 15: Detail of Ticehurst House Hospital register of admissions (1881-1890). Image: Wellcome Library.

I would also like to continue working with the UT project team to apply workflows and technologies developed for the LPH archives at other institutions. For example, the Mississippi Department of Archives and History (MDAH) is working currently with the University of Mississippi Medical Center (UMMC) to identify the approximately 1,000 bodies that were found on UMMC grounds last year and were once patients at the Mississippi State Insane Asylum. MDAH has custodianship of the asylum records and has processed the collection, which includes documents from the hospital's inception up to the time the facility was relocated in 1935. [64] The archives is in the process of creating high-quality scans of the hospital records. MDAH will need to

[64] http://zed.mdah.state.ms.us/cgi-bin/koha/opac-detail.pl?biblionumber=73937

develop a database for their digitized materials, especially since UMMC has intentions of using the records to identify the bodies (Mississippi State Asylum Cemetery Project, 2013). The MDAH/UMMC collaboration could serve as project partners with the LPH project and serve as a test case for any database and digital archives innovations, thus illustrating broader application of the LPH work.

My dissertation is the cornerstone of what I hope will become a rich and diverse corpus of multidisciplinary research by myself and others that focuses on the social ecologies of records from Larch Point Hospital and other mental institutions. By providing partial perspectives regarding the hundreds of thousands of patients and personnel that have passed through the hospital, Larch Point's surviving historical collection is a vital epistemological component for the critical examination and eventual understanding of hospital life. In the past, the records mediated human relationships, actions, and thoughts, and, today, the objects continue to affect individuals from several overlapping social arenas. The emotional, intellectual, and professional impact of the documents has not and will never be negligible, as people's complex positive and negative associations with the records are steeped inextricably in the constantly fluctuating socio-cultural dynamics from which the hospital emerged and has worked within for over 140 years. As the established managers of historical institutional documents and influential participants within record ecologies, information professionals must ensure the long-term preservation of mental health record collections such as those at Larch Point Hospital, as well as the judicious access to the information that they hold. They furthermore must be steadfast advocates for the incorporation of the viewpoints and roles of previously silent actors and unacknowledged actants into the archives because, in doing so, they can facilitate the articulation of existing power structures and take collaborative steps toward a more complete cultural record.

Appendix A: Interview Questions

The following is the line of questioning that I developed in order to prepare for the interviews.

Questions for Former and Current Staff

I will start with prompts that will help the individual become more comfortable with me and the interview process.

- When did you begin working at the hospital? How long did you work there? What was your job title/s?
- Why did you decide to work at the hospital?
- When you began working at LPH, what would a typical day look like? Did these routines change later on?
- Did you socialize much with other staff from the hospital? What was the hospital community like?
- Did you interact much with patients?

Then I will ask the interviewee questions to address recordkeeping practices and how records were part of hospital activities.

- Did you create medical or administrative records on a daily basis? If so, what kind of records?
- How did you learn how to record patient information?
- What sort of information would you write down? Did all the collected information seem useful or relevant for you or the hospital? Did any of the information you wrote down seem surprising or necessary? Were there any details you felt should have been recorded but were not? [What information

was considered important by the respondent, e.g., for administration, cultural, or personal purposes?]

- Besides the official medical or administrative records, did you ever keep other notes for your own purposes? [To what extent do the existing official records reflect work that was conducted at the hospital?]
- After you created those records, who had access to them? Would anyone else in the hospital use the records? Did the patients or their families get to see the records?
- What happened to those records after they were no longer in use? Why was it important to save or destroy the records?
- If inactive records are still around today, do you think other people should be able to see them? In particular, what do you think of descendants gaining access? What about historians and other researchers?
- Where do you think the inactive records should be kept?
- Who should have control over inactive records? Does it matter how old the records are?

Questions for Individuals Interested in Historical Mental Health Record Collections

The interview will be structured around questions that are about the reasons why the interview subject is interested in mental health record collections. For those who have sought access to such collections, the questions will focus on the researcher's work and his/her research process. All interviewees will be asked about their attitudes toward historical hospital records as cultural artifacts, the current access restrictions on medical records, and the preservation of these collections

- Research interests

- What are your current research interests?
- What spurred your interest in these topics?
- Do you interact with others who have similar research interests as you do? If so, please describe those interactions.

- Research process
  - In the past, have you required access to hospital records for your research?
  - What types of information from hospital records are especially important for your research?
  - How did you find the location of the information or documents that you required?
  - Please describe the processes you have gone through in order to get access to the hospital records you required.
  - Are there any ways in which you think finding and/or getting access to the information you needed could have been made easier?
  - Have you ever been surprised by what you discovered during your research process? If so, what?
- Preservation
  - Should hospital records be preserved or are there instances when they should be destroyed?
  - Does it make sense to preserve hospital records even if they currently cannot be easily accessed by law?
- Access
  - If you had unlimited access to hospital records, what information would you want to see?
  - Do you think it is or is not important that access to hospital records (and other similar types of records with protected information) be restricted by law? Why?

    - Do you think certain groups of people, such as descendants of patients, should have greater access to historical hospital records than others? Why?
- Heritage
    - Do you consider hospital records to be cultural heritage?
- If so, please specify whose cultural heritage.
- Do you consider it to be part of your heritage?
    - If you do think hospital records are part of our/your/the world's/etc. heritage, at what point do they become so?

Appendix B: Example of CDA Core Elements

The following is an example of how I applied the core elements from the social actor's approach to critical discourse analysis. The data source is the first LPH register (1866-1887).

Element	Synopsis
Actions	The purpose of the categories is to classify incoming patients for administrative accountability to the state. Unlike later registers, this register is the only formal documentation of patients throughout their entire institutionalization; therefore, it may also have been used for patient care purposes.
Modes	The provided space for each patient entry is fifteen lines, although some entries have extensive patient updates written tightly in the margins or in the correspondence section. The staff increasingly repurposed the latter to record hereditary predispositions to mental illness and the frequency and length of "attacks" (or "symptoms," as they are called later), thus suggesting a growing medical interest in studying familial and individual patterns of mental disease.
Actors	Besides the doctors and staff members who wrote in the registers and the state government that required the records, there are the implicated or silent actors, the patients, whose bodies and minds were examined and recorded. Expanding upon the element, I also consider the *actants* that create and reproduce social structures – in this case, the register itself. The register assisted the staff in determining where to place patients and how to care for them. Keeping in mind that patients often were institutionalized for their entire lives, some individuals fell under the care of multiple staff members over many decades, with the registers being the only source of written information about them.
Styles	The diction of the category titles indicates the inchoate state of American psychiatry at the time of the register's creation. Disease diagnoses and etiology were uncertain, as seen in categories such as "*Apparent* form of disease" and "*Supposed* cause of lunacy" (italics mine). Toward the end of the 19th century, more technical and detailed medical terminology appears under these categories, which coincides with psychiatry's growth as a discipline.
Times	Once the hospital determined its register categories, this register – by simply being a part of the facility's everyday practices – helped perpetuate the use of the same recordkeeping system for 21 years, even when the categories became insufficient for the hospital's medical and administrative needs. Later registers speak to the changes in institutional psychiatry, and include

	categories for legal statuses, race, syphilis testing, and addictions, among others.
Spaces	Based on the purpose of the register and the critical information it held, the volume most likely had a dedicated space within the hospital. From the text alone, it is impossible to determine if recordkeeping in the register took place near patient intake or at a separate location. By the mid-20th century, the hospital had a separate building for medical record management and storage.
Resources	Again, the materiality of the *actant* comes into play here. The register is a single bound volume, limiting the space for the hospital personnel to write information about the patients and perpetuating the use of certain categories over an extended period of time.

Appendix C: Full Coding Schema

Family	Code (times applied)	Definition
Changes over time	Administrative shift (113)	Changes in individuals for specific positions; additions/subtractions of positions; reorganization of all or part of institutional structure
	Commemoration/historical (71)	Recognition or application of historical significance to an institution or person; intent for preservation and remembrance
	Deinstitutionalization (10)	Actions toward deinstitutionalization
	Development of psychiatry (100)	Actions toward forwarding the medical knowledge or professionalization of psychiatry
	Etiology (14)	Efforts to understand and name the causation of mental illness or disability
	Hospital conditions (182)	Physical structures and living conditions at institution
	Technological developments (49)	Explicit or implicit changes in technology that changes how the institution, its counterparts, and its Board functions, e.g., communication, recordkeeping, medical practice
Diseases	Alcoholism (10)	Mentions alcoholism as a societal problem
	Drug addiction (4)	Any mention of drug addiction, especially as a psychiatric problem
	Geriatric (13)	Any mention of geriatric patients, housing, or care
	Hepatitis (4)	Mention of hepatitis
	Polio (1)	Mention of polio
	Syphilis (12)	Diagnosis and treatment of syphilis; syphilis as a disease
	Tuberculosis (12)	Mention of tuberculosis, its diagnosis, treatment, care, and housing of patients with the disease
	Typhoid (5)	Mention of typhoid, care and treatment of those diagnosed with typhoid

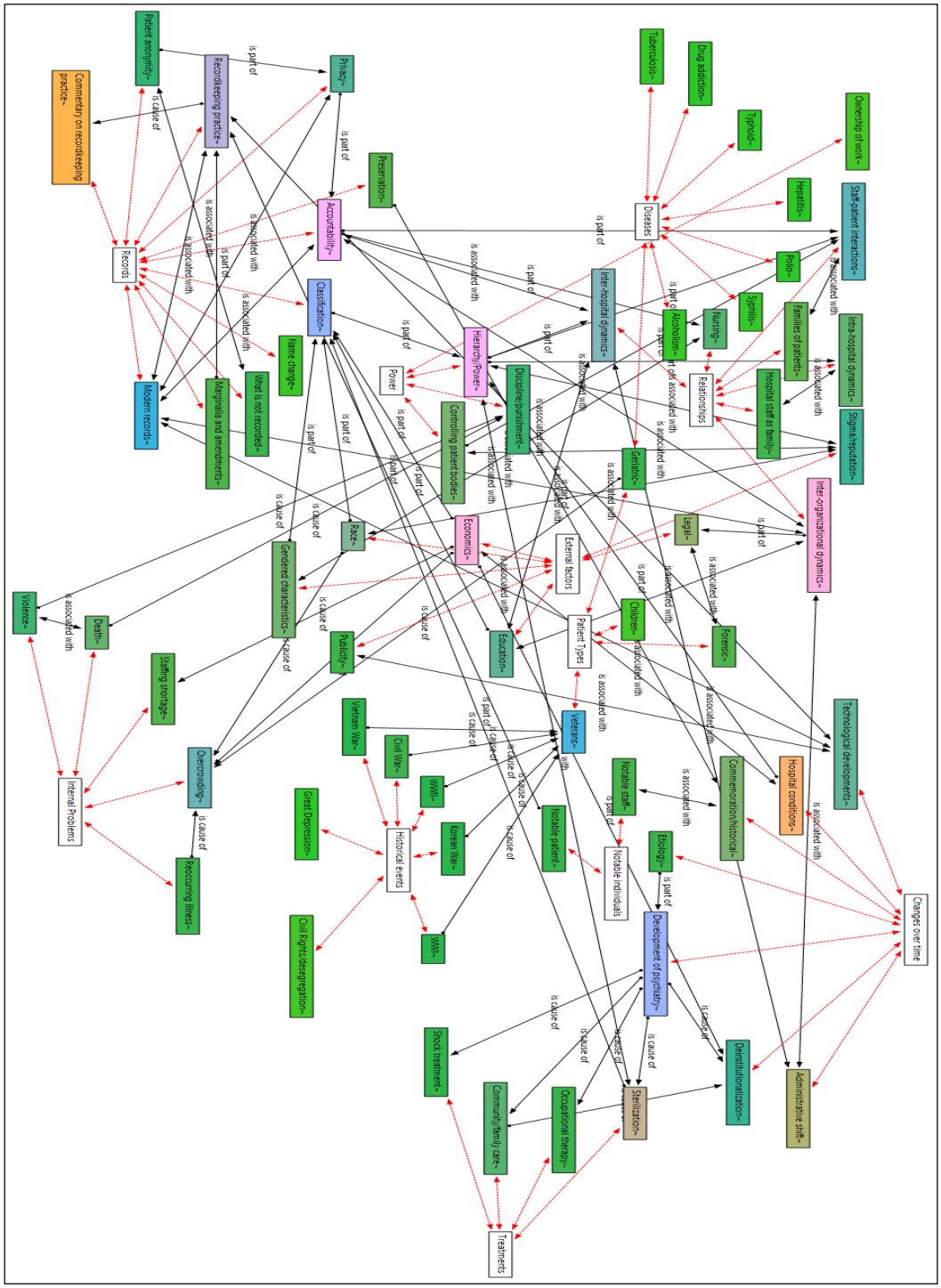
External factors	Economics (206)	Text that relates to finances
	Education (45)	Efforts toward intellectual development, whether of staff or patients
	Gendered characteristics (61)	Gender biases, gendered roles, or any other notable instance of gender playing a part in the action
	Legal (89)	Legal matters, including court cases and laws
	Publicity (18)	Event or action in which one or more of the hospitals will be or has been presented to the public
	Race (77)	Explicit or implicit indication of race or ethnicity as a factor in the action or event described or as worthy of being recorded
	Stigma/reputation (15)	Popular notions about mental hospitals and mental illness that are not always accurate and based on rumors
Historical events	Civil Rights/desegregation (23)	Civil Rights Act of 1964 and resulting desegregation
	Civil War (19)	Aftermath of Civil War
	Great Depression (2)	Relating to the Great Depression
	Korean War (1)	Related to Korean War
	Vietnam War (1)	Mention of Vietnam War
	World War I (2)	Mention of World War I
	World War II (1)	Mention of World War II
Internal problems	Death (49)	Any mention of death or dying of patients, staff, etc.
	Overcrowding (53)	Too many patients and not enough space and/or staff; the problems related to overcrowding
	Reoccurring illness (15)	When patients are described as returning over and over to the hospital
	Staffing shortage (35)	Explicit or implicit mention of lack of staff to adequately serve patient population

	Violence (17)	Description of a violent incident
Notable individuals	Notable patient (13)	Patient situation that has been recorded, usually for the unusual circumstances
	Notable staff (25)	Administrative or staff member who has been specifically mentioned and either has significance to the institution's development/history or was in an unusual situation
Patient types	Children (24)	Mentions children
	Forensic (34)	Related to the treatment, care, or housing of individuals deemed incapable of standing trial for crimes committed
	Geriatric (13)	Any mention of geriatric patients, housing, or care
	Veterans (26)	Indication of patients who served in the military; classification of veterans; services for veterans
Power	Controlling patients' bodies (64)	Actions that imply the hospital staff have physical power over patients' bodies and their actions
	Discipline/punishment (14)	The disciplining of patients or staff for crimes or misdeeds committed
	Hierarchy/power (177)	Action or statement that suggests an underlying hierarchical structure and/or power dynamic at work
	Ownership of work (27)	Expression of pride in work and/or ethical responsibility toward job
Records	Accountability (184)	Actions in which accountability is one of the primary objectives
	Classification (88)	The organization and separation of individuals (e.g., patients, staff) based on perceived difference in mental status, physiology, work status, etc.
	Commentary on recordkeeping practice (213)	Actor within text mentions recordkeeping practice, especially in regard to changes to the practice or questions/challenges to it

	Marginalia and amendments (30)	Marginalia or amendments (often hand) written after primary record was created
	Modern records (10)	Commentary on modern records and current recordkeeping practices, especially those done by the speakers themselves
	Name change (13)	Changes in names of institutions or positions
	Patient anonymity (5)	Instances in which patient identity is not provided, whether intentionally or unintentionally
	Preservation (41)	Reference to the preservation of records
	Privacy (37)	Attitude toward the privacy rights of patients, patients' families, and/or employees in regard to medical records
	Recordkeeping practice (116)	Notable recordkeeping action
	What is not recorded (16)	Indications in the recordkeeping that more discussions or communications occurred that were not recorded in these records or at all
Relationships	Families of patients (45)	Descriptions of interactions with families of patients, including descendants
	Hospital staff as family (21)	Implication that the relationships between and among administration and staff are familial
	Inter-hospital dynamics (74)	Indication of relationship between hospitals, whether VA state mental hospitals or with other hospitals
	Intra-organizational dynamics (201)	Indication of relationship of hospital or administration with non-hospital entities, including state and federal governments
	Intra-hospital dynamics (48)	Relationships within the hospital, especially between different types of employees
	Nursing (35)	The profession or practice of nursing

	Staff-patient interactions (40)	Single incidences or daily routines in which staff members or member interacts with patients or a patient
Treatments	Community/family care (37)	Care provided outside of the physical institutions but still associated with hospitals, especially as continued care
	Occupational therapy (14)	Treatment that calls for patients to work to develop practical manual labor skills and social skills, and to stay busy
	Shock treatment (6)	Mention of shock treatment as a type of therapy for mental illness
	Sterilization (127)	Text about the practice of sterilization, including the patients, doctors, legal issues, and economics involved

Appendix D: Network Map of Codes



Key to interpreting network map:

- White boxes indicate code family
- Red lines connect codes with families
- Black lines show relationships between codes
- Recall that **groundedness** refers to the number of times I applied a code to the data, and **density** refers to the number of times I connected a code to another code
    - Codes with high groundedness and high density are pink
        - I used this code often for my data and found many connections with other codes.
        - E.g., inter-organizational dynamics, hierarchy/power, economics, accountability
        - These codes indicated to me the dominant themes in my research.
    - Codes with high groundedness but low density are yellow
        - I applied this code many times in the data but did not make many connections with other codes.
        - E.g., commentary on recordkeeping practice, hospital conditions, administrative shift, sterilizations
        - This category of code points to subject matter or actions that fall under other codes (e.g., administrative shifts are part of inter-organizational dynamics) and are therefore not directly connected to many other codes, but appear frequently in the data and especially in the archival records (the larger of the two collected data types).
    - Codes with low groundedness and high density are blue
        - I did not see many instances in which to apply this code to the data, but I found to be connected to many other codes.
        - E.g., recordkeeping practice, classification, modern records

        - The low groundedness for many of these codes is misleading because the code may be a dominant but implicit theme throughout the data.
    - Codes with low groundedness and low density are green
        - I did not see many instances of this code in the data or made many connections with other codes.
        - E.g., name change, patient anonymity, Vietnam War
        - Many of these codes are subordinate to broader themes.

Appendix E: Ordered Situational Maps and Social World/Arenas Maps for LPH Registers

Ordered situational map of early patient admission register work (1870-1885):

External Influences

- By-laws about recordkeeping requirements
- Reconstruction South – social, political, racial environment
- Etiology and disease development over 15 years

Actors (Individual and Group)

- Superintendent
- Staff – different recorders over time
- Printer of registers
- Patients – recorded subjects
- Psychiatric profession

Actants (Objects and Places)

- Registers – physical object
- Hospital – setting

Object Characteristics

- Typed categories for information input
- Handwritten records – ink

Practice/Action Characteristics

- Shorthand

- Spelling errors
- Repurposing of record space
- Transferring of patients/explanations of death
- Updates from 1902 – physical and mental health, possessions

Social Elements

- Gendered diagnoses
- Race – especially mixed race
- Descriptions of violence to and by patients

Social Worlds/Arena Map (in list form) of early patient admission register work (1870-1885):

- Arena: patient admission register recordkeeping
    - Focus: To keep records of patient admissions, including initial reasons for being admitted and ongoing information-keeping (specifically, deaths, releases, and ongoing health)
    - Silences:
        - The recordkeeping process by staff, doctors, nurses, administration
        - Information-gathering process of patient information
        - Diagnoses decision-making
        - Patients' voices in the admitting process (however, there are a few instances of specific details and stories *about* individual patients)
    - Contested topics
        - Diagnoses and etiology – not "contested" but certainly in development and variable

        - Patient deaths – when patients are transferred to LPH and die suddenly, the register is a record of the hospital not being at fault
        - The ideal way to record patients – what categories, level of detail
        - Aging patients – an unexpected issue for the hospital; besides overcrowding and care, how will their health statuses be updated over many decades given the space limitations?
- Worlds
    - State legislature
    - Doctors
    - State hospital board
    - LPH board
    - Nurses
    - Hospital staff
    - Other hospitals
    - Law enforcement
    - Judicial system
    - Caretakers/guardians of admitted patients
    - Local book binders
    - Pen and ink manufacturers
    - Psychiatry associations
    - Medical associations

Ordered situational map of patient admission register work (1925-1940):

Actors

- Youth admitted for mental deficiencies
- Record keepers (staff, doctors)
- African American patients of various racial and ethnic backgrounds

Actants (objects, places)

- Admission registers
- The hospital

Practice/action characteristics

- Extensive categorization of patients
- Wassermann testing extremely common, but not a formal category until 1933
- Development of color categorization
- Multiple types of psychosis diagnoses
- Male/female patient distinction in terms of registration layout
- Readmissions (multiple times)
- Detailed causes of death
- Unknown letter notations by patient names
- Unused categories by 1939: War Service (veteran status notations resumed later), Use of Drugs, Paralytic [etc.], Blind [etc.], Hereditary
- Unused categories by 1940: Age Psychosis Began, Number Children If Female
- Repurposing of right-facing page to accommodate more patient admissions (only key categories are retained)

External influences

- Wassermann testing extremely common, but not a formal category until 1933
- Multiple types of psychosis diagnoses
- Detailed causes of death
- Development of color categorization

Social Worlds/Arena Map (in list form) patient admission register work (1925-1940):

- Arena: patient admission register recordkeeping
    - Focus: To keep records of patient admissions, including past (prior admissions, durations of attacks), ongoing (marital condition, environment), and future (discharged, died) conditions.
    - Silences:
        - The recordkeeping process remains opaque
        - Information-gathering process of patient information – who collects and records? Multiple record keepers?
        - Diagnoses decision-making – diagnoses becoming increasingly complex
        - Patients' voices in the admitting process or throughout their time at the hospital – none, compared to earlier registers
    - Contested topics
        - Diagnoses and etiology – still in development
        - The ideal way to record patients, including their race/color and how many categories to include
        - How to record new tests and procedures, such as the Wassermann
- Worlds
    - Nurses & Staff at hospital
    - Doctors at hospital
    - Administrators at hospital
    - Patients at hospital
    - Psychiatric/medical community
    - Bookbinders
    - Politicians

Ordered situational map of patient admission register work (1955-1970):

Actors

- Record keeping staff (doctors? nurses?)
- Patients – different statuses dependent on type of admission

Actants

- Patient admission registers
- The hospital as facility for mentally ill

Practice/action characteristics

- Continued admission of the very young and the very old; less elderly by the late 1960s
- Other recording medium/media to note individual patient's medical history, diagnosis, and treatment
- Legal status noted: Legal Status, Changes in Legal Status
- Type of admission noted: Date of Commission, Type of Admission
- Unlabeled category for veteran status
- Unlabeled category for diagnoses
- Unlabeled category for previous register numbers
- Unknown letter notations by patient names
- Readmissions (multiple times)
- Informal hospital transfer category indicating transfers of African American patients from St Elizabeths and other state hospitals
- All patients are labeled as Mentally Ill except the children, who are labelled as Mentally Deficient
- Veteran status, including if Active, noted by 1970

- First admission register notation of white patients arriving to LPH is told through transfers in March 1, 1967
- Race designation starting in 1969: N/W

External influences

- Forensic courts
- State legislature
- Facility for mentally deficient
- Other state hospitals
- Transportation for patients moved to LPH

Social elements

- Civil Rights Act of 1964
- Multiple 20th-c. wars: WWI, WWII, Korea

Social Worlds/Arena Map (in list form) of patient admission register work (1955-1970):

- Arena: patient admission register recordkeeping
    - Focus: To keep records of specific patient admission information prior admissions, legal status (a significant change), veteran status, and transfers
    - Silences:
        - The recordkeeping process remains opaque in the sense that it is not clear who is maintaining records, and why unofficial categories are being added
        - Information-gathering process of patient information

        - Patient histories, diagnoses, and treatment disappear from this record genre/medium
        - Patients' voices
    - Contested topics
        - Which categories to include – e.g., addition of categories to check discharge statuses, include diagnoses, include veteran statuses, race notation
        - Lack of consistent use of unofficial categories and using a controlled vocabulary for them, especially in regard to veteran status, transfer status, and discharge status
- Worlds
    - Nurses & Staff at hospital
    - Doctors at hospital
    - Administrators at hospital
    - Patients at hospital
    - Courts
    - Politicians
    - Other state mental facilities (within and outside of state)
    - Producers of recordkeeping technologies – tape recorders, patient forms, registers

Appendix F: Ordered Situational Maps and Social World/Arenas Maps for Board Minutes

Ordered situational map of board meeting minutes work (1870-1885):

Actors

- Board of Directors
- President of Board of Directors
- Secretary
- Superintendent
- Executive Committee

Actants

- Board meeting minutes
- Annual Report
- By-Laws
- Construction of physical buildings and other structures

Object characteristics

- Handwritten

External elements

- Judicial system
- City government
- General Assembly
- Land owners and descendants
- State political groups

- Sheriffs (law enforcement)
- State treasurer

Practice/action characteristics

- Verbatim copies of important letters
- Language of enclosure (to keep patients in)
- Language to describe patients: idiots (later: also imbeciles) and lunatics
- Listing of financial bills for approval
- Recorded version of verbal Superintendent reports
- Minutes as written evidence of important incidents "spread upon the Record" (crimes, violence, misbehavior, complaints)
- Patient death reports and explanations
- Farmer's report
- Health of the institution reports

Social characteristics

- Recorded instances of racial tensions
- Overturn of Board (March 9, 1882)

Financial characteristics

- Local bank
- Financial state of institution (income, expenses)
- Appropriations
- Salaries
- Supply contracts
- Location of institution

Social Worlds/Arena Map (in list form) of board meeting minutes work (1870-1885):

- Arena: board meeting minutes recordkeeping
    - Focus
        - To record the monthly business meetings of the hospital board's Executive Committee and (less frequently) the entire Board of Directors; reports from the Superintendent keep the Board up-to-date on the daily activities of the hospital, including farming, finances, construction, overall health of the patients, and numbers of patients. The Board also discuss their ongoing relationship with the General Assembly and Governor.
    - Silences
        - Rarely heard voices: patients' families, ward attendants
        - Never heard voices: patients and their experiences beyond conditions that necessitate Board action (e.g., overcrowding, escapes) and reported health incidents (e.g., outbreaks, violence)
        - The work of the Secretary
        - Basis for format of committee meetings and minutes recording style
    - Contested topics
        - Board upheavals leads to different secretaries and differing styles of board meeting minute recording
- Worlds
    - Hospital doctors > Superintendent
    - Board of Directors > Executive Committee
    - Patients
    - Attendants and other staff, e.g., Matron, Steward, Farmer

- State government, e.g., General Assembly, Governor, Treasurer
- Local businesses, e.g., butcher, coal provider, wood supplier
- Land owners
- Bookbinder

Ordered situational map of board meeting minutes work (1925-1940):

Actors

- Special Board of Directors of LPH
- Attorney General
- Commissioner/Chair of Board
- Superintendent
- Governors
- State Board of Public Welfare (inspections) > Bureau of Mental Hygiene
- Guardian ad litem for sterilization cases
- Medical staff: not enough, foreign
- Non-medical staff: clerk/bookkeeper, stenographers
- General Board of Hospital Directors
- Patients' families (usually in the form of letters of complaint)

Actants

- LPH
- Criminal Building

Object characteristics

- Newsy and dense
- Handwritten

- Superintendent's reports
- News about staff (dismissals, absences)
- Patient incidents (deaths, accidents, abuse)
- Sterilization cases listed and presented (first time: August 1928)
- Overt religious references, e.g., passages from Bible for deceased colleagues
- No minutes from 1937 to 1943

External elements

- National landmark committee
- Local bank
- Circuit Court
- Leprosy colony
- U.S. Veterans Bureau
- City government
- State Board of Health
- Rise of radiology/roentgenology
- Diseases: typhoid and syphilis

Practice/action characteristics

- Intra-hospital communication and cooperation
- Land negotiations
- Visits to out-of-state hospitals
- Teaching clinics held at LPH
- Occupational therapy
- Fire safety, e.g., inspections, sprinklers
- Overcrowding

Social characteristics

- Commemoration (first time: July 1929)
- Holiday events
- Segregation of patients across hospitals based on race
- Segregation of patients in hospital based on tidiness
- Gendered roles for patients (type of work) and staff (no female administrators)

Financial characteristics

- Costs for hospital improvements
- Costs for goods and services, e.g., coal
- Patients' store
- State appropriation cuts
- Loss of ex-servicemen to VA facility
- Insurance
- Capital Outlay
- No voluntary patients (rather, they are "indigent") = LPH is charitable institution [note: compare to superintendent noting in May 1968 that few Blacks voluntarily institutionalized]

Social Worlds/Arena Map (in list form) of board meeting minutes work (1925-1940):

- Arena: board meeting minutes recordkeeping
    - Focus: to share, discuss, and decide on matters relating to LPH, including the Superintendent's monthly reports, finances, land, staffing, patient care, construction and remodeling, utilities, and inter-organizational communication and cooperation.
    - Silences

        - While patients up for sterilization do get to petition their cases, their words do not appear in the minutes
        - The voices of nurses, attendants, and other caretakers
        - The legal decisions behind sterilization and the medical reasoning behind popular treatment decisions
        - Segregation
    - Contested topics
        - Tension of LPH being near land up for commemoration by federal government
        - What to do with a patient who of ambiguous ethnicity (see Jan. 1925)
        - The payment of patients who are employed as therapy
        - The division of land, especially in relation to electric and train companies
- Worlds
    - Special Board of Directors
    - Doctors, including Superintendent
    - Nursing staff, including occupational therapists
    - Attendants
    - Administrative staff, including stenographers and cleric/bookkeeper
    - Patients
    - Patients' families
    - Other state mental institutions
    - Out-of-state mental institutions
    - Medical schools
    - State government, including Governor and Attorney General
    - City government (lesser extent)
    - Utilities and goods producers

Ordered situational map of board meeting minutes work (1955-1970) [expanded using categories from Clarke, p. 90]

Individual Actors

- Chairman
- Commissioner
- Director of Division of Mental Hospitals
- Business Manager
- Supervising Architectural Engineer
- Superintendents
- Stewards
- Administrative Services Directors (as of June 1957) → Assistant Superintendents (Administrative) (as of Oct. 1964)
- Clinical Director → Assistant Superintendent (Clinical)
- Capital Outlay Project Director
- Governor

Collective Actors

- State Hospital Board
- State Department of Mental Hygiene and Hospitals
- State Legislature
- Joint Commission on Accreditation
- State Association for Mental Health
- American Psychiatric Association
- Social workers
- Local Building Committees
- Sterilization Committees

- State Board of Medical Examiners
- LPH
- Other facilities
- Medical college

Silent actors/actants

- Patients
- Patients' families
- Attendants

Discursive constructions of actors

- Board approval of patients who will be sterilized
- Hospitals as understaffed and custodial, rather than cutting-edge and community-oriented
- Tension of what medical professionals want/need and what state system can give them
- State Board as being within a hierarchical web of public and private organizations at city/state/regional/national levels
- The Board's adaptations to social changes in psychology, health care, and race

Actants

- Meeting minutes
- Agendas (separate from minutes)
- Executive sessions (after Board sessions)
- Psychiatric Residency Training Program
- Additional site for possible hospital expansion
- Criminal Building

- National Park Service

Discursive construction of actants

- [negotiations to achieve mutually beneficial outcomes]

Object characteristics

- Typed several days after meeting
- Stamped when received by LPH
- Signed by Chairman and Commissioner
- Carbon copies
- Official minutes in State Hospital Board office (Oct. 1968)

Discourses

- Lists of voluntary patients (stopped Aug. 1964)
- Lists of sterilizations performed and approved (stopped Aug. 1964)
- Discussions and development of new facilities
- Discussions about employees – problematic behavior, 40-hour workweek, pay, uniforms
- Discussions about patients – investigations of escapes, injuries, and deaths to determine negligence
- Licensing of private homesteads then clinics
- Minutes for evidence and recall (June 1956)
- Minute length/summarization (Aug. 1957; July 1961)
- Statistical summary
- Waiting list
- New business
- Resolutions for retired individuals

- Rated bed capacities
- Construction (internal)
- Construction (external)
- Overcrowding: geriatric patients, TB patients
- Epidemics: hepatitis, TB

Spatial elements

- Need for hospital in northern part of state
- Negotiation of old spaces with new needs
- Presence of architect at Board meetings
- Draining of LPH lakes

Social/cultural elements

- Family care
- Occupational therapy
- Use of drugs in treatment
- Holiday events
- Community mental health centers (Dec. 1967)
- Segregated employee facilities (Building Committee, June 1956)
- Race relations (Feb. 1956; Feb. 1957)
- Overcrowding
- Patient escapes and riots
- Stopping of farming
- Female Board members
- Commemoration (March 1961; Feb. 1966; Oct. 1966; Jan. 1968; Nov. 1968; Oct. 1969; Dec. 1970)
- Alcoholism

- Mental retardation

Economic/political elements

- Civil Rights Act, Title VI, and the "geographic plan" (Dec. 1966; March 1967; April 1967; June 1967; Sept. 1967; Dec. 1967)
- Public image (April 1967)
- Decentralization (Dec. 1970)
- Cattle scandal at another facility
- Audits
- Hospital budgets
- Reimbursement rates

Temporal elements

- Recording technologies such as microfilm, photographs, audio tapes, and film
- Changes to patient forms (Aug. 1958; Sept. 1970)
- Records management (Sept. 1956)
- Desegregation
- Deinstitutionalization

Social Worlds/Arena Map (in list form) of board meeting minutes work (1955-1970):

- Arena: board meeting minutes recordkeeping
    - Focus: to record the meetings of the State Hospital Board (and LPH Local Building Committee), in which board members discuss the monthly matters of the state mental facilities, which may include patient and/or staff incidents, finances, construction/remodeling/demolition, health care

techniques and training, and interactions with other organizations and institutions.

    - Silences:
        - Executive Sessions are not recorded in the minutes
        - The voices of patients and their families
        - Voices of attendants and (rarely) of nurses
        - Legislative decision-making
        - Attitudes toward desegregation
    - Contested topics
        - What medical professionals want career-wise and what the state mental health system can offer
        - Changes in how the mentally ill and mentally disabled are treated, e.g., sterilizations, shock treatment, drugs, occupational therapy, outpatient clinics, community rehabilitation
        - The implementation of changes to daily activities, e.g., 40-hour workweek, staff uniforms, distribution of minutes

- Worlds
    - State Hospital Board
    - Hospital staff
    - State government
    - Professional societies
    - Medical schools
    - Patients and relatives
    - Federal government
    - Clinics

Bibliography

Abbott, A. (1997). Of time and space: The contemporary relevance of the Chicago School. *Social Forces, 75*(4), 1149-82.

Accountability. (2011). In *Oxford English Dictionary* online. Retrieved from http://www.oed.com.ezproxy.lib.utexas.edu/view/Entry/1197

Allen, L. M. (2010). A critique of four grounded theory texts. *The Qualitative Report, 15*(6), 1606-1620. Retrieved from http://www.nova.edu/ssss/QR/QR15-6/allen.pdf

Anderson, B. (1991). *Imagined communities*. New York, NY: Verso.

Anderson, N., & Dietrich, M. (Eds.). (2012). *The educated eye: Visual culture and pedagogy in the life science*. Hanover, NH: Dartmouth College Press.

APA Practice Organization. (2014). The HIPAA Privacy Rule: FAQs. *Practice Central*. Retrieved from http://www.apapracticecentral.org/business/hipaa/faq.aspx

Appadurai, A. (Ed.) (1986). *The social life of things: Commodities in cultural perspective*. Cambridge: Cambridge University Press.

Appel, J.W., & Beebe, G.W. (1946). Preventive psychiatry: An epidemiologic approach. *Journal of American Medical Association, 131*(18), 1469-1475.

Assmann, J., & Czaplicka, J. (1995). Collective memory and cultural identity. *New German Critique,* 65, 125-133.

Associated Press. (2008, January 18). HIPAA bars release of hospital burial records, Neb. judge rules. *First Amendment Center*. Retrieved from http://www.firstamendmentcenter.org/hipaa-bars-release-of-hospital-burial-records-neb-judge-rules

Associated Press. (2013, August 16). Lawmakers to hold hearing on former Crownsville hospital. *The Daily Record*. Retrieved from http://thedailyrecord.com/2013/08/16/lawmakers-to-hold-hearing-on-former-crownsville-hospital/#ixzz3OdZwSysq

Bardzell, J. (2009, March 9). Two takes on the hermeneutic circle. *Interaction Culture*. Retrieved from http://interactionculture.wordpress.com/2009/03/09/two-takes-on-the-hermeneutic-circle/

Bastian, J. (2003). *Owning memory: How a Caribbean community lost its archives and found its history*. Westport, CT: Libraries Unlimited.

Behrnd-Klodt, M. (2008). *Navigating legal issues in archives*. Chicago, IL: Society of American Archivists.

Berg, M., & Bowker, G. (1997). The multiple bodies of the medical record: Toward a sociology of an artifact. *The Sociological Quarterly, 38*(3), 513-537.

Bever, L. (2014, October 2). Dallas hospital blames 'flaw' in 'workflow' for release of Ebola patient as a more complete picture of his travels emerges. *The Washington Post*. Retrieved from http://www.washingtonpost.com/news/morning-mix/wp/2014/10/02/dallas-hospital-blames-flaw-in-electronic-record-keeping-system-for-release-of-ebola-patient/

Bloch, M. (1962). *The historian's craft*. New York, NY: Knopf.

Blouin, F. (1999). Archivists, mediators, and the constructs of social memory. *Archival Issues, 24*(2), 101-112.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Englewood Cliffs, NJ: Prentice-Hall.

Boles, F., & Greene, M. (1996). Et tu Schellenberg? Thoughts on the dagger of American appraisal theory. *The American Archivist, 59*(3), 298-310.

Booms, H., Joldersma, H., & Klumpenhouwer, R. (1987). Society and the formation of a documentary heritage: Issues in the appraisal of archival sources. *Archivaria*, 24, 69-107.

Bourdieu, P. (1991). *Language & symbolic power*. Cambridge, MA: Harvard University Press.

Bowker, G.C. (2001). Bonnie Nardie and Vicki O'Day, information ecologies: Using technologies with heart. *Computer Supported Cooperative Work, 10*(1), 143-145.

Bowker, G.C., & Star, S.L. (1999). *Sorting things out: Classification and its consequences*. Cambridge, MA: MIT Press.

Bruemmer, B., & Hochheiser, S. (1989). *The high-technology company: A historical research and archival guide*. Minneapolis, MN: Charles Babbage Institute, Center for the History of Information Processing, University of Minnesota.

Cartwright, S. (1851). Diseases and peculiarities of the Negro race. *De Bow's Review: Southern and Western State, 4*. Retrieved from http://www.pbs.org/wgbh/aia/part4/4h3106t.html.

Chandler, R.C., & Plano, J.C. (1988). *The public administration dictionary*. Santa Barbara, CA: ABC-Clio.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.

Christen, K. (2011). Opening archives: Respectful repatriation. *The American Archivist, 74*(1), 185-210.

Clarke, A.E. (2005). *Situational analysis: Grounded theory after the postmodern turn*. Thousand Oaks, CA: SAGE.

Cohen, S., & Scull, A. (Eds.). (1983). *Social control and the state*. Oxford, UK: Martin Robertson.

Common Rule, 45 CFR §46 (1991).

Cook, T. (2001). Archival science and postmodernism: New formulations for old concepts. *Archival Science,* 1, 3-24.

Cook, T. (2006). Macro-appraisal and functional analysis: Documenting governance rather than government. *Journal of the Society of Archivists, 25*(1), 5-18.

Cox, R. (2004). *No innocent deposits: Forming archives by rethinking appraisal*. Lanham, MD: Scarecrow Press.

Cox, R. (2009). The archivist and community. In J. Bastian, & B. Alexander (Eds.), *Community archives: The shaping of memory* (pp. 251-264). London, UK: Facet Publishing.

Cox, R. (2011). Technology's promise, the copying of records, and the archivist's challenge: A case study in documentation rhetoric. In T. Cook (Ed.), *Controlling the past: Documenting society and institutions* (pp. 131-149). Chicago, IL: Society of American Archivists.

Craig, B. (1989). Hospital records and record-keeping c. 1850 - c. 1950 Part I: The development of records in hospitals. *Archivaria,* 29, 57-87.

Craig, B. (1990). Hospital records and record-keeping c. 1850 – c. 1950 Part II: The development of record-keeping in hospitals. *Archivaria*, 30, 21-38.

Dandeker, C. (1990). *Surveillance, power and modernity: Bureaucracy and discipline from 1700 to the present day*. New York, NY: St. Martin's Press.

Daniel, P. (1979). The metamorphosis of slavery, 1865-1900. *The Journal of American History, 66*(1), 88-99.

Danielson, E.S., & Eppard, P.B. (2013). The archivist as scholar: Ethics, challenges, and rewards. *Archival Outlook*, March/April, 3, 26-27.

Dant, T. (2005). *Materiality and society*. Maidenhead, UK: Open University Press.

Department of Health and Human Services. (2003, April 3*). Office of Civil Rights HIPAA Privacy*. Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/research.html

Department of Health and Human Services. (2006, March 14). *Health Information Privacy*. Retrieved from http://www.hhs.gov/ocr/privacy/hipaa/faq/right_to_access_medical_records/221.html

Department of Health and Human Services. (2011, July 26). Human subjects research protections: Enhancing protections for research subjects and reducing burden, delay, and ambiguity for investigators (HHS-OPHS-2011-0005). *Federal Register, 76*(143), 44,512-44,531.

Department of Health and Human Services. (2013, January 25). Modifications to the HIPAA privacy, security, enforcement, and breach notification rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; other modifications to the HIPAA Rules (78 FR 5565). *Federal Register, 78*(17), 5,565-5,702.

Derrida, J. (1980). *La carte postale: de Socrate à Freud et Audela.* Paris, France: Flammarion.

Dey, I. (1999). *Grounded theory: Guidelines for qualitative inquiry*. San Diego: Academic Press.

Diagnostic and statistical manual of mental disorders. (2000). 4th ed. Washington, D.C.: American Psychiatric Association.

Dilthey, W. (1991, originally published in 1883). *Selected works (vol. 1): Introduction to the human sciences*. Princeton, NJ: Princeton University Press.

Downs, J. (2012). Sick from freedom: African-American illness and suffering during the Civil War and Reconstruction. New York, NY: Oxford University Press.

Duff, W., & Harris, V. (2002). Stories and names: archival description as narrating records and constructing meanings. *Archival Science, 2*(3-4), 263-285.

Dunbar, A. (2006). Introducing critical race theory to archival discourse: Getting the conversation started. *Archival Science, 6*(1), 109-129.

Duranti, L. (1994). The concept of appraisal and archival theory. *The American Archivist, 57*(2), 328-344.

Eastwood, T. (1992). Toward a social theory of appraisal. In B. Craig (Ed.), *The archival imagination: Essays in honour of Hugh Taylor* (pp. 71-89). Ottawa: Association of Canadian Archivists.

Eastwood, T. (1993). Nailing a little jelly to the wall of archival studies. *Archivaria,* 35, 232-252.

Ecology. (2008). In *Oxford English Dictionary* online. Retrieved from http://www.oed.com.ezproxy.lib.utexas.edu/view/Entry/59380

Edwards, R., & Usher, R. (2008). *Globalisation and pedagogy: Space, place and identity*. London, UK: Routledge.

Elliott, R.L., Wolber, G., & Ferriss, W. (1997). A survey of hospital staff attitudes toward ethically problematic relationships with patients. *Administration and Policy in Mental Health, 24*(5), 443-449.

Ernest, J. (2004). *Liberation historiography: African American writers and the challenge of history, 1794-1861*. Chapel Hill, NC: University of North Carolina Press.

Fairclough, N., & Wodak, R. (1997). Critical discourse analysis. In T.A. Van Dijk (Ed.), *Discourse as social interaction* (pp. 258-284). Thousand Oaks, CA: Sage.

Family Education Rights and Privacy Act of 1974, 20 U.S.C. § 1232g; 34 CFR Part 99 (1974).

Foote, K.E. (2003). *Shadowed ground: American's landscapes of violence and tragedy*. Austin, TX: University of Texas Press.

Foster, S. (1990). The pragmatics of culture: The rhetoric of difference in psychiatric nursing. *Archives of Psychiatric Nurses, 4*(5), 292-297.

Foucault, M. (1984). What is an author? In P. Rabinow (Ed.), *The Michel Foucault reader* (pp. 101-120). (C. Porter, Trans.). New York, NY: Pantheon.

Foucault, M. (1995, originally published 1975). *Discipline & punish*. (A. Sheridan, Trans.). New York, NY: Vintage Books.

Foucault, M. (2006, originally published 1961). *History of madness*. (J. Murphy & J. Khalfa, Trans.). London, UK: Routledge.

Freeman, J., & Audia, P. (2006). Community ecology and the sociology of organizations. *Annual Review of Sociology,* 32, 145-169.

Gambino, M. (2008). "These strangers within our gates": Race, psychiatry and mental illness among black Americans at St. Elizabeths Hospital in Washington, DC, 1900-40. *History of Psychiatry,* 21, 206-223.

Garfinkel, H. (1984, originally published 1967). *Studies in Ethnomethodology*. Malden, MA: Polity Press/Blackwell Publishing.

Garner, B.A. (1995). *A dictionary of modern legal usage*. 2nd ed. Oxford, UK: Oxford University Press.

Gibson, P., & Denby, R. (2007). African American mental health: A historical perspective. In S. Logan (Ed.), *Mental health care in the African-American community* (pp. 3-14). New York, NY: Haworth Press.

Giddens, A. (1984). *The constitution of society: Outline of the theory of structuration*. Berkeley, CA: University of California Press.

Gilliland, A.T., & Wiener, J.A. (2011). Digitizing and providing access to privacy-sensitive historical medical resources: A legal and ethical overview. *Journal of Electronic Resources in Medical Libraries, 8*(4), 382-403.

Glaser, B. G. (1992). *Basics of grounded theory analysis: Emergence verses forcing*. Mill Valley, CA: Sociology Press.

Glaser, B.G., & Strauss, A.L. (1965). *Awareness of dying*. Chicago, IL: Aldine Publishing Company.

Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine Publishing Company.

Goffman, E. (1961). *Asylums: Essays on the social situations of mental patients and other inmates*. New York, NY: Anchor Books.

Gramsci, A. (1971). *Selections from the Prison Notebooks of Antonio Gramsci*. (Q. Hoare & M.N. Smith, Eds. & Trans.). New York, NY: International Publishers.

Greene, M. (2002). The power of meaning: The archival mission in the postmodern age. *The American Archivist, 65*(1), 42-55.

Greene, M. (2003). The messy business of remembering: History, memory, and archives. *Archival Issues, 28*(2), 96-104.

Greene, M., & Meissner, D. (2005). More product, less process: Revamping traditional archival processing. *The American Archivist, 68*(2), 208-263.

Grob, G. (1972). *Mental institutions in America: Social policy to 1875*. New York, NY: Free Press.

Grob, G. (1983). *Mental illness and American society, 1875-1940*. Princeton, NJ: Princeton University Press.

Grob, G. (1991). *From asylum to community: Mental health policy in modern America*. Princeton, NJ: Princeton University Press.

Gronfein, W. (1985). Incentives and intentions in mental health policy: A comparison of the Medicaid and Community Mental Health programs. *Journal of Health and Social Behavior, 26*(3).

Haggerty, K.D., & Ericson, R.V. (2000). The surveillant assemblage. *British Journal of Sociology, 51*(4), 605-622.

Ham, G. (1975). The archival edge. *The American Archivist, 38*(1), 5-13.

Hamilton, C. (2002). "Living by fluidity": Oral histories, material custodies and the politics of archiving. In C. Hamilton et al. (Eds.), *Refiguring the archive* (pp. 209-228). Norwell, MA: Kluwer Academic Publishers.

Haraway, D. (1988). Situated knowledge: The science question in feminism and the privilege of partial perspective. *Feminist Studies, 14*(3), 575-599.

Harris, V. (2007). *Archives and justice: A South African perspective*. Chicago, IL: Society of American Archivists.

Harris, V. (2011). Ethics and the archive: "An incessant movement of recontextualisation". In T. Cook (Ed.), *Controlling the past: Documenting society and institutions* (pp. 345-362). Chicago, IL: Society of American Archivists.

Hart-Davidson, W. (2000). Confessions of a gardener: A review of information ecologies. *ACM Journal of Documentation, 24*(2), 79-84.

Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1938 (1996).

Hedstrom, M. (2002). Archives, memory, and interfaces with the past. *Archival Science*, 2, 21-43.

Hilton, C. (2013, August 11). Digitising the asylum. *Wellcome Library*. Retrieved from http://blog.wellcomelibrary.org/2013/11/digitising-the-asylum/

Hochschild, A.R. (1983). *The managed heart: Commercialization of human feeling*. Berkeley, CA: University of California Press.

Horsman, P. (1999). Dirty hands: A new perspective on the original order. *Archives and Manuscripts, 27*(1), 42-53.

Horsman, P., Ketelaar, E., & Thomassen, T. (2003). New respect for the old order: The context for the Dutch Manual. *The American Archivist, 66*(2), 249-270.

Horwitz, T. (2015). Did Civil War soldiers have PTSD? *Smithsonian Magazine*. Retrieved from http://www.smithsonianmag.com/history/ptsd-civil-wars-hidden-legacy-180953652/?no-ist

Huvila, I. (2008). Participatory archive: Toward decentralised curation, radical user orientation and broader contextualisation of records management. *Archival Science, 8*(1), 15-36.

Ingleby, D. (1983). Mental health and social order. In S. Cohen, & A. Scull (Eds.), *Social control and the state* (pp. 141-188). Oxford, UK: Martin Robertson.

Institution. (1989). In *Oxford English Dictionary online*. Retrieved from http://www.oed.com.ezproxy.lib.utexas.edu/view/Entry/97110

Jary, D., & Jary, J. (Eds.). (1991). *The HarperCollins dictionary of sociology*. New York, NY: HarperPerennial.

Jenkinson, H. (1944). British archives and the war. *The American Archivist, 7*(1), 1-17

Jimerson, R. (2009). *Archives power: Memory, accountability, and social justice*. Chicago, IL: Society of American Archivists.

Jimerson, R. (2011). How archivists "control the past". In T. Cook (Ed.), *Controlling the past: Documenting society and institutions* (pp. 363-379). Chicago, IL: Society of American Archivists.

Jung, C. (1930). Your negroid and Indian behavior. *Forum, 83*(4), 193-199.

Jussim, E. (1989). *The eternal moment: Essays on the photographic image*. New York, NY: Aperture.

Kessel, M., & Hopper, J. (2011, November 7). Victims speak out about North Carolina sterilization program which targets women, young girls and blacks. *Rock Center*. Retrieved from http://rockcenter.nbcnews.com/_news/2011/11/07/8640744-victims-speak-out-about-north-carolina-sterilization-program-which-targeted-women-young-girls-and-blacks

Ketelaar, E. (2005). Sharing: Collected memories in communities of records. *Archives & Manuscripts*, 33, 44–61.

Klein, H.K., & Myers, M.D. (1999). A set of principles for conducting and evaluating interpretive field studies in information systems. *MIS Quarterly, 23*(1), 67-93.

Koppell, J. (2005). Pathologies of accountability: ICANN and the challenge of "multiple accountabilities disorder. *Public Administration Review, 65*(1), 94-108.

Lamberg, L. (1998). Gay is okay with APA – forum honors landmark 1973 events. *Journal of the American Medical Association, 280*(6), 497-499.

Latour, B. (2005). *Reassembling the social: An introduction to Actor-Network-Theory*. New York, NY: Oxford University Press.

Latour, B., & Woolgar, S. (1986, originally published 1979). *Laboratory life: The construction of scientific facts*. Princeton, NJ: Princeton University Press.

Lawrence, S. (2007). Access anxiety: HIPAA and historical research. *Journal of the History of Medicine and Allied Sciences, 62*(4), 422-60.

Lewis, G. (1994, February 11). Dozens is oral legacy rooted in survival. *The Baltimore Sun*. Retrieved from http://articles.baltimoresun.com/1994-02-11/features/1994042244_1_mothers-dirty-dozens-censures

Logan, S. (2007). Mental health interventions and the Black community. In S. Logan (Ed.), *Mental health care in the African-American community* (pp. 39-55). New York, NY: Haworth Press.

Loricchio, L. (2013, September 18). O'Malley assigns group to investigate abuses at Crownsville State Hospital. *Capital News Service*. Retrieved from http://cnsmaryland.org/2013/09/18/omalley-assigns-group-to-investigate-abuses-at-crownsville-state-hospital/

Marquardt, T. (2013, June 5). Tragic chapter of Crownsville State Hospital's legacy. *Capital Gazette*. Retrieved from http://www.capitalgazette.com/cg-tragic-chapter-of-crownsville-state-hospitals-legacy-20140730,0,2239704.story

McKemmish, S. (2002). Placing records continuum theory and practice. *Archival Science, 1*(4), 333-359.

Mississippi State Asylum Cemetery Project. (2013). Mississippi State University. Retrieved from http://msacp.cobb.msstate.edu/index.html

Mississippi Department of History and Archives. (n.d.). *Sovereignty Commission Online: Collection Description*. Retrieved from http://mdah.state.ms.us/arrec/digital_archives/sovcom/colldesc.php

Mead, G.H. (1934). *Mind, self, and society.* Chicago, IL: University of Chicago Press.

Mead, G.H. (1964). *Selected writings: George Herbert Mead*. A.J. Reck. (Ed.). Chicago, IL: University of Chicago Press.

Metzl, J. (2009). *The protest psychosis: How schizophrenia became a Black disease*.

Boston, MA: Beacon Press.

Micale, M. (1993). On the "disappearance" of hysteria: A study in the clinical deconstruction of a diagnosis. *Isis, 84*(3), 496-526.

Mol, A. (2002). *The body multiple: Ontology in medical practice.* Durham, NC: Duke University Press.

Mol, A. (2008). *The logic of care: Health and the problem of patient choice.* New York: Routledge.

Muller, S., Feith, J., & Fruin, R. (1968, originally published 1898). *Manual for the arrangement and description of archives*. New York, NY: The H.W. Wilson Company.

Nardi, B.A. & O'Day, V.L. (1999). Information ecologies: Using technology with heart. *First Monday, 4*(5). Retrieved from http://firstmonday.org/htbin/cgiwrap/bin/ojs/index.php/fm/article/view/672/582

National Public Radio. (2006). Story behind the number: Literacy and lynchings. Retrieved from http://www.npr.org/templates/story/story.php?storyId=5189912

Ngin, P. (1994). Recordingkeeping practices of nurses in hospitals. *The American Archivist, 57*(4), 616-630.

Norman, D. (2002). *The design of everyday things*. New York, NY: Basic Books.

North, M. (2002). *Greek medicine: The Hippocratic Oath*. U.S. National Library of Medicine. Retrieved from http://www.nlm.nih.gov/hmd/greek/greek_oath.html

Novak, S. (2005). Testimony for the January 11, 2005 NCVHS Subcommittee on Privacy and Confidentiality Hearings. Retrieved from http://ncvhs.hhs.gov/050111p5.htm

Olson, L.M. (1995). Record keeping practices: Consequences of accounting demands in a public clinic. *Qualitative Sociology, 18*(1), 45-70.

Onion, R. (2014, November 6). History, or just horror? *Slate*. Retrieved from http://www.slate.com/articles/news_and_politics/history/2014/11/old_medical_photographs_are_images_of_syphilis_and_tuberculosis_patients.html

Ostrom, E. (1990). *Governing the commons: The evolution of institutions for collective action*. New York, NY: Cambridge University Press.

Otto, T. (2013). *St. Elizabeths Hospital: A history*. Washington, D.C.: U.S. General Services Administration.

Pearce-Moses, R. (2005). Records continuum. *Glossary of archival and records terminology*. Retrieved from http://www2.archivists.org/glossary/terms/r/records-continuum

Petrila, J. (2000). Legal and ethical issues in protecting the privacy of behavior health care information. In J.J. Gates, & B.S. Arons (Eds.), *Privacy and confidentiality in mental health care* (pp. 91-125). Baltimore, MD: Paul H. Brookes.

Pickering, A. (1995). *The mangle of practice: Time, agency, and science*. Chicago, IL: University of Chicago Press.

President's New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America*. *Retrieved* from http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/toc.html

Privacy Rule, 45 CFR §160, §164 (2002).

Prosser, W. (1960). Privacy. *California Law Review, 48*(3), 383-423.

Punzalan, R. (2009). "All the things we cannot articulate": Colonial leprosy archives and community commemoration. In J. Bastian, & B. Alexander (Eds.), *Community archives: The shaping of memory* (pp. 197-220). London, UK: Facet Publishing.

Ranney, F.J. (2000). At the heart of information ecologies: Invisibility and technical communication. *ACM Journal of Documentation, 24*(2), 85-90.

Ransom, R.L., & Sutch, R. (2001). *One kind of freedom: The economic consequences of emancipation*. Cambridge, UK: Cambridge University Press.

Ricoeur, P. (1970). *Freud and philosophy: An essay on interpretation*. New Haven: Yale University Press.

Riedlmayer, A., & Naron, S. (2009). From Yizhor Books to weblogs: Genocide, grassroots documentation and new technologies. In J. Bastian, & B. Alexander (Eds.), *Community archives: The shaping of memory* (pp. 151-167). London, UK: Facet Publishing.

Rose, J. (2011, June 22). N.C. considers paying forced sterilization victims. *National Public Radio*. Retrieved from http://www.npr.org/2011/06/22/137347548/n-c-considers-paying-forced-sterilization-victims

Rosenberg, C. (1987). *The care of strangers: The rise of America's hospital system*. New York, NY: Basic Books.

Ruane, M. (2014). After 150 years, a famous patient is finally identified. *Smithsonian Magazine*. Retrieved from http://www.smithsonianmag.com/history/discovering-the-identity-of-a-150-year-old-patient-4563869/

Sack, K. (2011, September 8). Patient data posted online in major breach of privacy. *The New York Times*. Retrieved from http://www.nytimes.com/2011/09/09/us/09breach.html

Saloy, M.L. (1998). African American oral traditions in Louisiana. *Folklife in Louisiana*. Retrieved from http://www.louisianafolklife.org/LT/Articles_Essays/creole_art_african_am_oral.html

Samuels, H. (1986). Who controls the past. *The American Archivist, 49*(2), 109-124.

Schellenberg, T. (1961). Archival principles of arrangement. *The American Archivist, 24*(1), 11-24.

Scull, A. (1983). Humanitarianism or control? Some observations on the historiography of Anglo-American Psychiatry. In S. Cohen, & A. Scull (Eds.), *Social control and the state* (pp. 118-140). Oxford, UK: Martin Robertson.

Sedgwick, P. (1982). *Psycho politics: Laing, Foucault, Goffman, Szasz, and the future of mass psychiatry*. New York, NY: Harper & Row.

Selfe, D., & Hayden, D. (2000). A review and applications of information ecologies. *ACM Journal of Documentation, 24*(2), 91-102.

72-Year Rule, Pub L. 95-416, 92 Stat. 915 (1978).

Shenton, A. (2004). Strategies for ensuring the trustworthiness in qualitative research projects. *Education for Information,* 22, 63-75.

Shilton, K., & Srinivasan R. (2008). Participatory appraisal and arrangement for multicultural archival collections. *Archivaria,* 63, 87-101.

Skloot, R. (2010). *The immortal life of Henrietta Lacks*. New York, NY: Broadway Books.

Smith, C. (2005, May 27). In memoriam: The Austin State Hospital Cemetery is the long final home for thousands. *The Austin Chronicle*. Retrieved from http://www.austinchronicle.com/news/2005-05-27/272559/

Solove, D. (2006). A taxonomy of privacy. *University of Pennsylvania Law Review, 154*(3), 477-564.

South Carolina Department of Archives and History. (n.d.). *Public records information leaflet no. 7: Microfilm and microforms*. Retrieved from http://rm.sc.gov/leaflets/Documents/SEVEN.pdf

Star, S.L., & Griesemer, J.R. (1989). Institutional ecology, "translations" and boundary objects: Amateurs and professionals in Berkeley's Museum of Vertebrate Zoology, 1907-39. *Social Studies of Science, 19*(3), 387-420.

Star, S.L., & Strauss, A. (1999). Layers of silence, arenas of voice: The ecology of visible and invisible work. *Computer Supported Cooperative Work, 8*(1-2), 9-30.

Starr, P. (1982). *The social transformation of American medicine*. New York, NY: Basic Books.

Stobbe, M. (2011, February 28). U.S. had many human guinea pigs. *Arizona Daily Star*. Retrieved from http://www.npr.org/2011/06/22/137347548/n-c-considers-paying-forced-sterilization-victims

Stoler, A. (2006). Colonial archives and the arts of governance: On the content in the form. In F. Blouin (Ed.), *Archives, documentation, and institutions of social memory: Essays from the Sawyer Seminar* (pp. 267-279). Ann Arbor, MI: University of Michigan Press.

Stoler, A. (2009). *Along the archival grain: Epistemic anxieties and colonial common sense.* Princeton, NJ: Princeton University Press.

Strauss, A. (1985). Work and the division of labor. *The Sociological Quarterly, 26*(1), 1-19.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage.

Strauss, A., Schatzman, L., Erlich, D., Bucher, R., & Sabshin, M. (1963). The hospital and its negotiated order. In E. Friedson (Ed.), *The hospital in modern society* (pp. 147-169). New York, NY: Free Press.

Strauss, A., Fagerhaugh, S., Suczek, B., & Wiener, C. (1997, originally published 1985). *Social organization of medical work*. New Brunswick, NJ: Transaction Publishers.

Summers, M. (2010). "Suitable care of the African when afflicted with insanity": Race, madness, and social order in comparative perspective. *Bulletin of the history of medicine*, 84, 58-91.

Szasz, T. (1974). *The myth of mental illness: Foundations of a theory of personal conduct*. New York, NY: Harper & Row.

Taylor, C. (1971). Interpretation and the sciences of man. *The Review of Metaphysics, 25*(1), 3-51.

Taylor, H. (1982). The collective memory: Archives and libraries as heritage. *Archivaria*, 15, 118-130.

Taylor, H. (1995). "Heritage" revisited: Documents as artifacts in the context of museums and material culture. *Archivaria*, 40, 8-20.

Taylor, H. (2003). *Imagining archives: Essays & reflections*. Lanham, MD: Scarecrow Press.

Trace, C. (2002). What is recorded is never simply "what happened": Record keeping in modern organizational culture. *Archival Science*, *2*(1-2), 137-159.

Tremaine, D. (n.d.). Court decision ends a century of secrecy. *Davis Wright Tremaine LLP*. Retrieved from http://www.dwt.com/experience/uniEntity.aspx?xpST=ExperienceDetail&experience=6816

Trinkaus-Randall, G. (2011, October 26). Letter to Jerry Menikoff, Directors of the Office for Human Research Protections, U.S. Department of Health and Human Services.

Trouillot, M. (1995). *Silencing the past: Power and the production of history*. Boston, MA: Beacon Press.

Upward, F. (1997). Structuring the records continuum – part two: Structuration theory and record-keeping. *Archives and Manuscripts*, *25*(1), 10-35. Retrieved from http://infotech.monash.edu/research/groups/rcrg/publications/recordscontinuum-fupp2.html

Upward, F. (2000). Modelling the continuum as paradigm shift in recordkeeping and archiving processes, and beyond – a personal reflection. *Records Management Journal*, *10*(3), 115-139.

Urry, J. (1991). Time and space in Giddens' social theory. In C. Bryant, & D. Jary (Eds.), *Giddens' theory of structuration: A critical appreciation* (pp. 160-175). London, UK: Routledge.

U.S. National Archives and Records Administration. (n.d.). *Citizen Archivist Dashboard.* Retrieved from http://www.archives.gov/citizen-archivist/

Van Dijk, T. (2001). Principles of critical discourse analysis. In M. Wetherell, S. Taylor, & S.J. Yates (Eds.), *Discourse theory and practice* (pp. 300-317). Los Angeles, CA: Sage.

Van Leuuwen, T. (1996). The representation of social actors. In C.R. Caldas-Coulthard, & M. Coulthard (Eds.), *Texts and practices: Readings in critical discourse analysis* (pp. 32-70). New York, NY: Routledge.

Wailoo, K. (2011). How cancer crossed the color line. New York, NY: Oxford University Press.

Warren, S. & Brandeis, L. (1890). The right to privacy. *Harvard Law Review*, *4*(5), 193-220.

Washington Times. (2004, June 28). Historic mental hospital closes. *The Washington Times*. Retrieved from http://www.washingtontimes.com/news/2004/jun/28/20040628-115142-8297r/?page=all

Weiner, D.B. (1990). Mind and body in the clinic: Phillipe Pinel, Alexander Crichton, Dominique Esquirol, and the birth of psychiatry. In G.S. Rousseau (Ed.), *The languages of psyche: Mind and body in Enlightenment thought* (pp. 331-404). Berkeley, CA: University of California Press.

Wielawski, I.M. (2014). OpenNotes: Putting medical record transparency to the test. *To Improve Health and Health Care, Vol. XVI*. Retrieved from

http://www.rwjf.org/content/dam/farm/books/books/2014/rwjf411535.

Wodak, R., & Meyer, M. (Eds.). (2009). *Methods of critical discourse analysis*. Thousand Oaks, CA: Sage.

Yakel, E. (2001a). An institutional view of electronic records management: Hospitals & teleradiology. *The Information Management Journal, 35*(1), 26-33.

Yakel, E. (2001b). The social construction of accountability: Radiologists and their record-keeping practices. *The Information Society*, 17, 233-245.

Yakel, E. (2011). Who represents the past? Archives, records, and the social web. In T. Cook (Ed.), *Controlling the past: Documenting society and institutions* (pp. 257-278). Chicago: Society of American Archivists.

Yakel, E., Shaw, S., & Reynolds, P. (2007). Creating the next generation of archival finding aids. *D-Lib Magazine, 13*(5/6).

Yates, J. (1989). *Control through communication*. Baltimore, MD: Johns Hopkins University Press.

Yeo, G. (2007). Concepts of record (1): Evidence, information, and persistent representations. *The American Archivist, 70*(2), 315-343.